Library

St. Olaf College

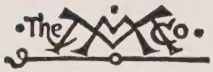
Northfield, Minn.

Digitized by the Internet Archive
in 2022 with funding from
Kahle/Austin Foundation

https://archive.org/details/mentalabnormalit0000sidn

MENTAL ABNORMALITY AND DEFICIENCY

An Introduction to the Study of Problems of Mental Health



THE MACMILLAN COMPANY
NEW YORK · BOSTON · CHICAGO · DALLAS
ATLANTA · SAN FRANCISCO

MACMILLAN & CO., LIMITED
LONDON · BOMBAY · CALCUTTA
MELBOURNE

THE MACMILLAN CO. OF CANADA, LTD.
TORONTO

MENTAL ABNORMALITY AND DEFICIENCY

AN INTRODUCTION TO THE STUDY OF PROBLEMS OF MENTAL HEALTH

BY

SIDNEY L. PRESSEY, PH.D.

ASSISTANT PROFESSOR OF PSYCHOLOGY IN THE OHIO STATE UNIVERSITY

AND

LUELLA COLE PRESSEY, PH.D.

INSTRUCTOR IN PSYCHOLOGY IN THE OHIO STATE UNIVERSITY

New York

THE MACMILLAN COMPANY

1926

All rights reserved

RC601
.B93

COPYRIGHT, 1926,
BY THE MACMILLAN COMPANY.

Set up and electrotyped.
Published March, 1926.

PRINTED IN THE UNITED STATES OF AMERICA BY
THE BERWICK & SMITH CO.

PREFACE

The authors have had two major purposes, in writing this brief volume.

They have, in the first place, attempted to formulate material for a college course which should give in vigorous, very direct, practical fashion acquaintance with the major problems of mental health, and mental disease and deficiency. As is pointed out in the first chapter, these problems are grave. They are, in a very peculiar and interesting way, largely dependent for their solution upon general knowledge concerning them. And study of these matters can give an understanding of human personality which could hardly be obtained otherwise. Under the circumstances, it would seem that every educated person should have some familiarity with the subject; a course dealing with these matters would seem an essential part of a liberal education. That this is not at present the case is due, the writers believe, in no small part to the lack of any satisfactory selection and organization of material for such a course. The average manual of psychiatry is too specialized, too medical in its approach. And books dealing with abnormal psychology are usually written from the point of view of some special theory, or deal primarily with symptoms and their classification, and the more bizarre episodes of mental disease. The writers have attempted a much broader treatment—have attempted not only to outline the primarily medical and psychiatric features of these problems of mental health, but also to show their even more fundamental relations to education, and to give some realization of the frequency

84457

with which matters involving mental abnormality appear in the affairs of everyday business and professional life. And they have tried to keep the discussion constantly in contact with common observation regarding personality, so that mentally abnormal and deficient individuals will be appreciated as real persons, not merely as asylum specimens or oddities of psychiatric practice.

The writers have, in the second place, attempted a treatment which should be of definite practical value to those interested in various special fields of work in which problems of personality and adjustment are frequently met; they have had in mind particularly social service, personnel management, work with delinquents, and those most important functionings of the school and college which involve the student's emotional and characterological development and his educational, vocational, and recreational guidance. There is thus frequent reference to the social worker, the court clinician, the personnel manager, and the individuals in the educational system (public school principal, school psychologist, college dean) who must most often deal with the maladjustments and emotional morbidnesses so common in later childhood and adolescence. The writers believe there is place for a book outlining the major facts, regarding mental ill-health and deficiency, with reference to the very practical needs of these various groups. They feel that a treatment should be possible which would take account of these special problems without making the volume less valuable to the reader of more general interests; such a treatment might even appeal to the general reader as more practically worthwhile.

The book is the result of several years of experience in teaching courses in abnormal psychology, the study of the feeble-minded, and the clinical study of school children. It outlines the writers' ideas as to desirable material for an introduction to and over-view of this general field—for what

might be called a course in "applied abnormal psychology." It is also the result of a rather unusual range of experience in actual work with abnormal and defective individuals, including (on the part of one author or another) nearly two years as resident psychologist at the Boston Psychopathic Hospital, social service work at the same institution, work of one sort or another in three schools for the feeble-minded, clinical experience in a juvenile court, a never-to-be-forgotten investigation regarding the insane and feeble-minded in certain parts of rural Indiana, and numerous and varied contacts with public school problems. The very careful organization and arrangement of the material, the general plan of supplementary reading, the case method of presentation (which has been thoroughly tried and found decidedly valuable in giving reality and interest), and the glossary, are all products of the teaching experience and will, the writers believe, make the book exceptionally clear and usable. From the personal contacts with these problems, in hospital, institution, court, field work, and school, have come the very concrete and practical method of approach, the numerous illustrative cases—and the writers' strong feeling regarding the very great importance of this whole subject, and the need for a more widespread understanding of these matters.

Acknowledgments are difficult to make. The general relation of the volume to the literature is indicated by the references, and suggestions for further reading. The chief debt is to the numerous physicians, institution officials, social workers, and public school people with whom the writers have worked and discussed these problems. However, mention should be made of their obligations to Dr. Arthur P. Noyes, First Assistant Physician, St. Elizabeth's Hospital, Washington, for careful reading of the first draft of the manuscript and valuable suggestions; and to Dr. J. E. Moser of Bloomington, Indiana, for his worthwhile comments on the manu-

script from the point of view of the general practitioner. Miss Helen Hare, formerly Chief of the Social Service of the Robert W. Long Hospital at Indianapolis, and Professor Shelley D. Watts, of the Department of Sociology of Indiana University, have also examined the material with special reference to its usefulness in the training of social workers.

S. L. Pressey,
L. C. Pressey.

Columbus, Ohio,
February, 1926.

CONTENTS

CHAPTER		PAGE
I	THREE LITTLE APPRECIATED FACTS REGARDING MENTAL DISEASE AND DEFICIENCY	1
	The Extent of Mental Disease and Disability	1
	The Possibilities in Treatment and Prevention of Mental Ill-health	5
	The Highly Individual Nature of Problems of Mental Abnormality	7
	PART ONE: METHODS OF CASE STUDY	
II	HISTORY TAKING	13
	The Essentials of a Case History	14
	History of the Present Crisis	16
	History of the Individual	19
	History of the Family	27
III	THE STUDY OF THE PRESENT CONDITION	35
	The Essentials of a Study of the Present Condition	36
	The Study of the Physical Condition	37
	Appearance and Behavior	41
	The Study of the Intellectual Condition	42
	The Study of the Emotional Condition	51
IV	THE TECHNIQUE OF CASE STUDY	59
	The Interview	60
	Other Sources of Information	63
	The Record	65
	The Summary and Conclusions	70
	Common Sense in Case Study	72
	References, Part I; and Exercises in Application	74

PART TWO: TYPES OF MENTAL DISEASE AND DISABILITY

CHAPTER		PAGE
V	The Classification of Mental Types and Diseases	81
VI	The "Normal" Individual	85
	The Average Family	86
	The Average Life	89
	The Examination of Average Individuals	92
VII	The "Borderland" Conditions	105
	The Emotionally Maladjusted	107
	The Emotionally Unstable	129
	The Mentally Peculiar	137
VIII	The Functional Psychoses	144
	Nature and Classification of the Psychoses	144
	Dementia Præcox	147
	Manic-Depressive Insanity	164
	Paranoia and Related Conditions	173
IX	The Organic Psychoses	181
	General Paresis	181
	The Toxic Psychoses	187
	Senile Psychoses	196
	Gross Brain Disease	198
	The Epilepsies	201
	Abnormal Conditions Associated with Certain Physical Diseases	208
X	The Feeble-minded	215
	What is Feeble-mindedness?	215
	The Classification of the Feeble-minded	217
	The Type Case	220
	The Diagnosis of Feeble-mindedness	223
	Treatment and Care of the Mentally Inadequate	226
	References, Part II; and Exercises in Application	237

PART THREE: MAJOR PROBLEMS, AND METHODS OF DEALING WITH THEM

CHAPTER PAGE

XI Some Problems of Differential Diagnosis . 243
Delinquency and Psychopathy 243
Economic Incompetency and Psychopathy . . 248
Non-educability and Psychopathy 249
Differentiation of Adolescent Pathological Mental Conditions 251
Mental Difficulties of Middle Age 253
Classification and Individualization in Diagnosis 253

XII Extent of Mental Disease and Disability . 255
The Number of Individuals in Institutions . . 255
The Number of "Institutional" Cases not in Institutions 258
Frequency of Borderland Conditions of Mental Disease and Deficiency 262
The Mentally Abnormal in Society 263

XIII The Causes of Abnormal Mental States (Etiology) 267
The Distinction between Predisposing and Exciting Causes 267
Predisposing Causes 268
Exciting Causes 274
The Responsibility of Society 276

XIV The Treatment of Atypical Mental Conditions 278
Treatment of Predisposing Causes 278
Treatment of Exciting Causes 283
The Care of Abnormal Individuals 284
After-care 287
The Adjustment of the Abnormal in School, Industry, and Social Life 289

CHAPTER PAGE

XV Mental Hygiene 292
Early Ideas Regarding Prevention of Mental Abnormality 292
Control of Feeble-mindedness 294
Control of Physical Factors Contributing to Mental Ill-health 295
Control of Mental Factors Contributing to Mental Ill-health 296
Maintaining One's Own Mental Health . . . 302
Cause and Prevention of Mental Difficulty by Society 305
References, Part III; and Exercises in Application 308

Appendix A The Case-study Outline 315

Appendix B Journals Dealing, Wholly or in Part, with Problems of Mental Abnormality and Deficiency 317

Annotated Bibliography 321

Glossary 333

Index 349

MENTAL ABNORMALITY AND DEFICIENCY

MENTAL ABNORMALITY AND DEFICIENCY

CHAPTER I

THREE LITTLE APPRECIATED FACTS REGARDING MENTAL DISEASE AND DEFICIENCY

This volume has been written with three exceedingly important, but not generally known, facts about mental disease and disability constantly in mind. These facts should first be thoroughly appreciated, if the various topics dealt with are to be understood in their full significance.

The Extent of Mental Disease and Disability

There is at present an army of over three hundred thousand individuals in institutions for the insane, the epileptic, and the feeble-minded in this country. Patients in hospitals for the mentally diseased almost equal in number those in all other hospitals combined. "In several states one out of twenty, of all people who die in adult life, dies in a hospital for the insane. From one-sixth to one-third of every state's expenditures is for the support of mental hospitals. There are more mental patients in the public institutions of the country than there are students in its colleges and universities." [1]

However, by no means all those who need care in institutions are receiving such care. Conservative estimates indicate that not more than four-fifths of the "insane" are being cared

[1] From a pamphlet, *Mental Hygiene: The Practical Aims of a Movement to Conserve Mental Health*, issued by the National Committee for Mental Hygiene. For the meaning of technical terms, see the glossary at the back of this volume.

for as they should be. Probably not one-half of the epileptics who should be in institutions are being thus properly supervised and treated. Extensive and carefully conducted surveys of entire communities have led to the conclusion that perhaps not one-tenth of the feeble-minded who should be in a state school for the mentally defective ever enter such an institution.[1]

But the above figures are no more adequate to indicate the magnitude of problems of mental health than a census of patients in hospitals for treatment of physical disease, plus estimates of the added number who should be in such hospitals, would show the total number of persons who suffer from some form of physical disease or disability. "Mental deficiency (feeble-mindedness) makes it impossible for approximately two per cent of the school population to carry on the work of even the lower grades. . . . Feeble minds are responsible for nearly a third of crime, for much minor delinquency, and for the continued existence of many other pressing social problems." . . . Various functional[2] nervous disorders, such as the episodes which are popularly called "nervous breakdown," are very common, and "take an immense number of useful people from their family, business, and social duties and wipe out in nervous invalidism a large share of their value to society."[3]

In fact, problems of mental health appear in practically every other large human problem. Thus in a large business

[1] For a fuller discussion of these matters, with references, see the chapter in this book on "Extent of Mental Disease and Disability."

[2] Attention is again called to the glossary at the end of this volume.

[3] The quotations are from the pamphlet referred to in note 1. The statements with regard to feeble-mindedness might perhaps best be modified somewhat in their connotation. But in general it cannot be said that the seriousness of the total situation is exaggerated. In this pamphlet Dr. William J. Mayo, of the Mayo Clinic, is quoted as saying, "Neurasthenia, psychasthenia, hysteria, and allied neuroses are the causes of more human misery than tuberculosis or cancer." And Dr. Harvey Cushing, Surgeon-in-Chief, Peter Bent Brigham Hospital, Boston (an internationally known surgeon), writes: "There is nothing which is possibly of more vital concern to the Nation than a knowledge of the mental disorders to which its citizens are subject."

concern nine per cent of the total time employees were absent from work because of illness, was the result of some form of nervous or mental difficulty; ten per cent of the employees at one time or another had some such difficulty.[1] Besides, there are a vast number of other problems met with in business which have their root in abnormalities or peculiarities of personality. An employee is a chronic trouble-maker, or is subject to periods of marked inefficiency; a foreman markedly and chronically antagonizes or cannot control his men; an executive develops marked irresponsibility in his management of the affairs entrusted to him—many, if not most, of such cases are fundamentally problems of mental health, and are most profitably dealt with from that viewpoint.

Problems met by the social worker are shot through and through by such factors. In fact, an eminent authority (the late Dr. E. E. Southard) has stated that "One out of every two cases of social trouble is a psychiatric case." A very large proportion of delinquent and criminal groups are most profitably considered from this same point of view. Many such individuals are feeble-minded. Some are definitely insane; some are epileptic. Others are what is sometimes known as "psychopathic personalities"; they are so peculiar, in emotional make-up, that they cannot be considered normal individuals. And a large proportion of the remainder are the products of such abnormal and morbid and socially "diseased" home and neighborhood environment that they cannot but be considered primarily problems of mental health and hygiene.[2]

Most important of all, from many points of view, is the problem of mental disease and disability in the schools. The problems presented by the subnormal children in the schools are now fairly well recognized. Somewhere around one or two per cent of children in the public schools may be con-

[1] Elkind, H. B., "Mental Hygiene in Industry," *Journal of Industrial Hygiene*, Vol. 6, pp. 113-23, July, 1924.

[2] For abundant material on this topic see Healy, William, *The Individual Delinquent*, Little Brown and Company. 1915. (Attention is also called to the annotated bibliography at the end of this volume.)

sidered feeble-minded. These children cannot profit by the usual course of study or learn by the usual methods of instruction. Another group is sufficiently subnormal to need a modified course of study and method.

Not so well known are problems of mental disease or peculiarity, as these appear in the schools. Some cases are so obvious that they cannot escape attention. Such are occasional cases of epilepsy. A few cases of major mental disease appear in the public schools; and they appear all too often in colleges and universities.[1] But other types of mental and nervous difficulty are hardly less important and much more frequent. Hysteria takes many and often obscure forms, especially in boys; there are many more cases of hysteria in the schools than most teachers realize. Cases of extreme excitability are comparatively common, and are, very likely, related to disturbances in the functioning of some one or more of the ductless glands. Most common of all are cases known to the school chiefly for a persistent extreme intractability or quarrelsomeness, equally persistent and extreme indifference, chronic and malicious mischief and vandalism,[2] or persistent petty thievery. These cases are, especially in high school and the upper grades, common—as every experienced teacher knows. Such individuals are usually best understood as suffering from a morbid emotional state, the product of unfortunate home conditions.[3]

[1] The writers have observed one undoubted case of mania (manic-depressive psychosis, manic phase) in a boy nine years old. The appearance at a state hospital of a high school student suffering from manic depressive insanity or dementia præcox is by no means an unusual occurrence. The writers have never been connected with any college or university in which they have not known of at least one case of dementia præcox. It is very unfortunate that most college officials are uninformed with regard to nervous and mental diseases.

[2] To be distinguished, of course, from occasional essentially good-natured episodes due primarily to overflow of animal spirits.

[3] For examples, see *Three Problem Children*, Joint Committee on Methods of Preventing Delinquency, Publication No. 2, 1924, p. 146; Healy, William, *Mental Conflict and Misconduct*, Little, Brown and Company, 1917; Laird, D. A., "Case Studies in the mental problems of later adolescence with special reference to the mental hygiene of the College Student, *Mental Hygiene*, Vol. 7, Oct., 1923; and the chapters

There is, then, (a) a good sized army of individuals in institutions for the insane and the feeble-minded in this country; there is (b) a still larger group of individuals not now in institutions, but who should be having institutional care; and (c) less extreme problems of mental health are to be found everywhere—in business, in the courts, in social agencies, in the schools, and colleges. It would, in fact, seem important for every well-informed person to have some understanding of these matters.

But there is an even more important reason why general acquaintance with these matters is desirable. Solution of the majority of these problems can be confidently expected, when knowledge regarding them becomes general.

The Possibilities in Treatment and Prevention of Mental Ill-health

Some mental diseases are due to physical factors which can be controlled to a very large degree, if public opinion is only educated to the point where the necessary measures will receive general support. This is true of syphilis. And syphilis is the cause of an almost invariably fatal form of insanity (general paresis), of certain types of feeble-mindedness, and is a chief or at least a contributing factor in various other nervous and mental conditions—besides being a very serious disease even when it does not affect the nervous system. Alcohol has been—and still is—one of the factors which keep full the state hospitals for the insane; and this factor also can be controlled, once public opinion is back of such control. The same statement can be made with regard to various drugs, such as cocaine.

It is more or less true that any factors tending to decrease physical health and resistance tend also to lower nervous tone and capacity to stand mental and emotional stress. In so far as this is true, all progress in medicine and hygiene involves

in this volume on "The Normal Individual" and "The Borderland Conditions," together with the references there given.

also progress toward greater general mental health and vigor. Great physical strain (as in child-birth), may result in more or less serious mental upsets. There is some evidence that even profound mental disturbances may result largely from focal infections, as in the teeth. With the development of medical science elimination of such causes presumably may be largely brought about. However, it is believed that the greatest progress in control of mental illness, and perhaps of mental deficiency also, will come from efforts in a different direction.

It is generally supposed that feeble-mindedness is primarily a matter of heredity, and so that prevention is hardly possible except by eugenic measures. However, evidence is accumulating that, in a very important sense, feeble-mindedness may be prevented by the right kind of training; the intellectually inferior individual may be trained to earn his own living and "conduct his affairs with prudence." That is, if a feeble-minded individual is brought up in an environment which is reasonably healthy, physically and emotionally, if he is required to undertake only such formal schooling as is within the limits of his capacities, if he is given vocational training in a kind of work suited to his ability and guided into such work upon leaving school, and if the community, the church, or some other agency furnishes him with healthy recreation and social contacts, it has been shown that he will usually be a self-supporting, moral, and happy member of society. A constructive, long-time program along these lines may be expected to accomplish remarkable things. In fact, as has recently been suggested, it may be that the feeble-minded will prove to be "one of the great undeveloped resources of the country."

However, even more important results, results contributing in some degree to the mental and emotional health of almost every person, may be expected from consistent attack upon certain other problems by methods now being developed from research in education and in mental hygiene. The great com-

monness of cases of mild mental and emotional difficulty has already been mentioned. Evidence is rapidly accumulating to show that a large proportion of such cases can be successfully treated. The treatment requires patience, a large understanding of human nature and the way personality develops, and intimate acquaintance with modern work in this field. The topic is more fully discussed in a later chapter (the Chapter on Treatment). It is necessary here only to reiterate that treatment, along lines relatively easily understood and according to relatively simple principles, may be expected to help these mild cases greatly, and often restore them almost completely to efficiency and happiness. There is some evidence that even in cases of marked mental disease, or insanity, such methods may be remarkably successful.

Even more important is the evidence that a large proportion of these mild mental difficulties may be prevented. Evidence is piling up to show that most cases of "nervous breakdown" and other difficulties met in everyday life, and even many cases of insanity, are the result primarily of unfortunate emotional habits which the proper home and school training would not have allowed to develop and of circumstances which might largely be avoided. What is more, when such training and mental hygiene does become general it may be expected to result not only in prevention of nervous and mental disease in individuals who might otherwise have so suffered, but in improved emotional health and efficiency for everyone.[1]

The Highly Individual Nature of Problems of Mental Abnormality

Many people seem to believe that mentally diseased individuals are a group definitely apart from other people; and it seems often assumed that the insane are all, in many re-

[1] The matter is discussed more fully in the chapter on "Mental Hygiene." As is there pointed out, the situation is one of great and peculiar promise, since general understanding of these conditions may be expected of itself to act largely as a preventative.

spects, very much alike. It is also the usual practice to talk about "the feeble-minded" as if this group of individuals were highly homogeneous. Even many specialists in this field seem to rest satisfied if they are able to classify a person as in a particular disease group—this person is pigeonholed as a hysteric, this other as a psychopathic personality, and so on. Most books dealing with this subject are misleading in that they generalize about the various types of mental difficulty with comparative neglect of individual peculiarities, and treat of abnormal "mental states" instead of abnormal individualities. As a matter of fact the abnormal person very often has *more* individuality than the average person; his chief difficulty is that he is, in the exact meaning of the word, peculiar. And his difficulties have developed through experiences, and as a result of an exceedingly intricate complex of causes, which make up in the aggregate a background different from that presented by any other case. Even the feeble-minded have distinct personalities of their own, which should be respected, and must be carefully studied, if their difficulties are to be understood. Particularly if anything constructive in the way of readjustment of an individual is to be attempted is it essential that all these specific details be considered. It is vital for a real comprehension of this subject that it be understood as essentially not a study of diseases, but of personalities. And the only adequate method for such study is the case method.

It follows that the best way to obtain an understanding of mental abnormality is by actual observation of abnormal individuals. It is therefore urged that every opportunity should be seized for visiting classes for subnormal children in the public schools, juvenile courts, reform schools, social agencies, employment offices, hospitals for the insane, and otherwise observing atypical people. Unfortunately such visits can hardly be frequent or extensive enough for observation of all types; and (most important of all) they do not permit of observation of a case over a considerable time, so that the

course of the disease may be understood. Lack of opportunity for such extended personal observation of abnormal individuals may be to a considerable extent compensated for, however, by study of concrete, vivid, first-hand descriptions of such cases. The writers have, therefore, included a considerable number of brief case studies. They have, further, added at the end of each section references to more extended case study reports. As many as possible of these should be read. They are fascinating *true* stories, ranging from Rabelaisian comedy to the deepest tragedy, vivid, intimate. They will do more than a dozen volumes of general discussion to make clear and real the various forms of mental difficulty, to bring home to the reader some realization of the burden of misery and unhappiness caused by such conditions, and to give a practical understanding of abnormal personalities which will bring recognition of, and ability to deal with, such cases when met in everyday life.

Let it be repeated that the matters dealt with in this book are no abstractions. A study of mental abnormality is a study of human personality with all that is therewith implied as to need for sympathetic understanding, broad viewpoint, appreciation of the complexity of human nature, and realization of the interplay of causes which go to make a human personality what it is.

To summarize, then; in beginning the study of mental disease and deficiency there are three important features of this subject which one should first thoroughly appreciate. (1) The various forms of mental disease and disability, especially the mild, preventable forms, are exceedingly common and important; everyone knows persons who are suffering from such conditions. (2) Mental ill health can in many cases be cured; and the vast majority of such conditions can be prevented. The one great prerequisite to such progress is general understanding and popular intelligence regarding these mat-

ters. Finally, (3) from one very important point of view any generalization concerning abnormal people is false to the facts; all study of the subject should be study of individuals; this book treats not of mental abnormality nor of diseased conditions, but of abnormal or diseased personalities. . . . The great importance of this whole subject, the hopefulness of the situation, and the very individual character of the topics dealt with,—these three facts should be kept constantly in mind throughout the study of this volume.

PART ONE

METHODS OF CASE STUDY

In any discussion of mental disease and deficiency, consideration of methods by which individuals suffering from such conditions are investigated and diagnosed would seem a logical first step. However, there are other more important reasons for the presentation of case study methods at this point. As was mentioned in the previous chapter, problems of mental deficiency and disease are in most respects highly specific; each individual presents a largely distinctive clinical picture. The only satisfactory method for studying this subject is, thus, the case method; and an early presentation of procedures used in case study is obviously needed. Further, problems of mental disease and disability are very important practical problems—problems met constantly by the social worker, personnel manager, school psychologist, and appearing more or less frequently in the experience of any professional or business man. Since the writers are attempting a treatment which should be of some aid in study of such practical problems of mental adjustment, methods for the study of "problem individuals" appear, again, of early importance. The first part of this book has, therefore, been devoted to methods of case study. The question to be answered is: What facts must be obtained about an individual in order really to understand him, and warrant a conclusion regarding his personality and ability; and how is such information best obtained? Chapter II deals with the facts to be covered regarding an individual's life prior to the present study of him. Chapter III discusses the topics to be investigated in determining the present condition. Chapter IV suggests ways in which the facts called for in the previous two chapters can be secured with the greatest efficiency, reliability, and tact, and properly recorded and utilized in the interests of the "patient."

It must be emphasized that the only way to come to a real understanding of methods of case study is actually to use such methods. The writers therefore urge that, as part of the study of the next three chapters, the reader apply all that is said regarding methods of case study by actually writing up the history of several individuals he knows, and about whom he has considerable information—a village oddity, a queer neighborhood character, or (if one's acquaintance has unhappily not included such individuals) some normal person, as a friend, or even oneself. The nature of the case is not important; the important thing is to choose a case about which one has enough information to permit the organizing of data along the lines suggested in these chapters. The work will be found decidedly interesting.

CHAPTER II

HISTORY TAKING

In beginning consideration of methods of case study it is first of all to be emphasized that adequate understanding of an abnormal individual (or a normal person either, for that matter), cannot be had simply from study of him as he is at a particular time, but only by becoming familiar with his previous life and the development of his personality. To put it in more technical terms—essential for the understanding of any one's present condition is the study of that person's "history." In fact, information about a person's history is usually more important than study of his present condition, in determining a diagnosis. And skill in "history taking" appears as, in many respects, more important than skill in observation of symptoms. So study of methods in history taking appears as prior, logically and psychologically, to the study of clinical types and symptoms.

In fact, the study of the history of a case and of the course of the disease is, as will be at once admitted by any medical man, of the greatest importance in dealing with purely physical ailments. In dealing with mental disease this is even more true—partly because in mental disease the symptoms are usually less clear-cut and distinctive of particular disease processes, partly because mental disease and peculiarity are usually the result of a long period of development, the causes often beginning to operate years before the difficulty comes to a head.

It may well be mentioned here that modern advances in the study of abnormal mental conditions have come largely through the taking of this large, comprehensive view of the

situation. The disease entities, as modern classifications run, are founded on consideration of the total course of the abnormal condition rather than upon intensive study of the symptom complex exhibited at a particular time. Two individuals, suffering from very different diseases, may seem to the observer to act almost wholly alike. But study of the histories of these two cases reveals differences of paramount importance, on the basis of which the outcome of the present condition may be predicted with a high degree of certainty. More is known now than thirty years ago about the social defective, the troublesome child in school, the delinquent, the school dunce, and the unemployable, because more is known about the childhood, the youth, the families of such cases. And in a given instance, the factory trouble-maker, the recidivist, the charities "rounder," can be more wisely dealt with because his total personality and the environment from which he comes can be appraised and taken account of. The social worker, who looks into these more remote facts, is coming to be appreciated as a very valuable adjunct to a court, hospital, or business house.

The present chapter, then, will be devoted entirely to indicating certain "minimum essentials" in the study of case histories. And the study of the case as he appears *now* in court, clinic, school, or social agency—which might seem to the beginner the important matter—will be given the subordination of a later chapter.

The Essentials of a Case History

In obtaining the history of a case it is essential, for the beginner at least, that an outline, at once brief and comprehensive, should be used. As will be mentioned in a later chapter, the beginner will soon discover that the facts cannot always be obtained in just this orderly fashion; but there is all the more need, on this account, for some scheme by which the facts may be given coherence.

It should be said at once that the outline presented below

indicates only main topics and is intended for use in a very free and elastic way. Elaborate and detailed outlines can be found in almost any psychiatry or social workers' manual, or can be obtained from clinics or social agencies (references including such outlines will be presented at the end of this section). But a simple and straightforward scheme which will direct, but not burden, the beginner is not to be had as easily. It should also be added that *facts with regard to all these points will not be necessary for every case.* It depends upon the case, and particularly upon the purpose for which the case is being studied. An employment manager will usually need very little of all this. A school principal or school psychologist should, on an important case, try to obtain some light on all these topics, but usually much less is sufficient—or, at least, has to suffice. The social worker will often need all that is suggested by this outline, and more.

The writers would, then, suggest the following topical outline, as indicative of the points about which an investigator should gather his facts.

I. History of the Family.
   A. Medical History.
   B. Social History.
   C. Educational History.
   D. Economic History.

II. History of the Individual.
   A. Medical History.
      In Childhood, Adolescence, and Adult Life.
   B. Social History.
      In Childhood, Adolescence, and Adult Life.
   C. Educational History.
   D. Economic History.

III. History of the Present Crisis.
   A. Medical History.
      Symptoms and Course.
   B. Social History.
      Symptoms and Course.
   C. Educational History.
      Symptoms and Course.
   D. Economic History.
      Symptoms and Course.

The general plan of this outline should be obvious at once. First, chronologically, is information about the "patient's" family, then information about the patient himself; next is the history of the patient's present illness—or more broadly (since the "illness" may be failure in school, a theft, a quarrel with a foreman, or some other social, educational, or economic difficulty), the history of the present crisis. In the history of the family, the individual, the present crisis, there are to be considered medical, social, educational, and economic factors.

What, now, are the detailed facts which may be gathered under each one of these heads? It should first be noted that in actual study of the case this outline is ordinarily used backwards. That is, the questioning naturally starts in with inquiries about the present difficulty, and works back toward the history of the individual and his family.[1] So first of all—what information is to be gathered concerning the present crisis?

History of the Present Crisis

It should be noted to start with that the crisis may be primarily in any one of the four fields of inquiry. The present difficulty may obviously be medical; the individual may be physically or mentally ill. Or the trouble may be primarily social; the individual may be in trouble with the police, neighbors, fellow-workmen, or members of the family. There may be trouble in school—the difficulty may be educational; or the trouble may be of an economic nature, the individual being unable to provide a living for himself or dependents. The history of the present crisis may, therefore, be exclusively medical, social, educational, or economic. But usually there are complications; perhaps physical illness brings economic or social difficulties. A mental disease may show itself first by family discord or other clash with the social environment. Or some torturing personal relationship may so upset and

[1] The best and most tactful approach certainly comes this way; yet social workers will sometimes start in mechanically, "Is there any insanity, feeble-mindedness, or epilepsy in your family?"

distract that efficient work becomes impossible, a morbid nervous condition develops, and the examiner is presented with medical, social, and economic factors, all conspiring to bring about the present crisis in the unhappy patient's life. It is the rule rather than the exception that difficulties will be found coexistent in more than one field of investigation.

In investigating these points it must be kept in mind that (a) the symptoms and (b) the course of the trouble must both be considered. The most striking symptoms will hardly be missed. But a description of the course of the disease is very likely to be left out by the beginner and this is very likely to mean, also, the omission of many symptoms which may lack the dramatic interest of the important episodes in the difficulty, but may be more important in exhibiting the settled trend of the individual's character. For instance, the fact that a young girl has attempted suicide is not likely to be missed even by the beginner; but much more important for the understanding of her condition are such undramatic facts as the appearance of a period of unusual vivacity and energy some time before, the more recent worry over nothing at all, and so on, which show the girl's underlying personality. It should be emphasized that many abnormal mental conditions are to be distinguished more by their course than by their symptomatology at a particular time; so if the difficulty has been of sudden onset, the implications to be drawn from this fact are very different from the conclusions one would make if the beginnings of the trouble were insidious, and dragged out over a long period of time.

It is not possible to indicate in great detail the questions concerning the present crisis, because present crises differ so markedly. It can be said simply that there should be full, patient, sympathetic inquiry into the individual's trouble, and all the attendant circumstances.

Thus suppose the case being studied is the depressed young woman mentioned above. Of course there will be sympathetic inquiry as to why she attempted to kill herself; and all the

circumstances will be looked into. The girl's explanation may be that she was in danger of losing her job. This statement must evidently be verified; it will very likely be found out later from the employer that this belief of the patient's had not the slightest justification. In any case, the examiners would not be content to stop with this simple explanation. There must be further inquiry about the girl's work to determine whether anything about the work, or any episode connected with it, might be important. A natural next step is to inquire as to relations with other people, as fellow-workers, friends (both of the same and the opposite sex), members of the family. There should also be questions as to the physical health—has the patient been suffering from headache, constipation, insomnia, loss of weight? If there have been any such symptoms the question next is as to when they first appeared and how persistent they have been. In short, every single bit of information which can be found regarding the patient, over the period of the crisis and just before, should be carefully gathered and weighed.

In the case above mentioned the crisis quite clearly was medical; there was a pathological depression obviously related to definite physical symptoms, beginning with them, and running a definite course. But the case may be altogether different. Thus the writers investigated recently a girl who was failing in school, and was committing petty thefts. The major symptoms were evidently educational and social. There had been no such difficulties prior to the present year, but now things were rapidly becoming worse. There were no physical difficulties—no symptoms of any physical disease. After getting the child's confidence it was found, however, that the symptoms had first made their appearance soon after the father's second marriage, that there was practically open warfare between the stepmother and the children. Inquiry of neighbors and others resulted in the conclusion that the stepmother was anxious to get rid of the children and was making the home life as unpleasant as possible for them. Partly, the

educational and social difficulties were the result of emotional stress. The social worker investigating the case reported the suspicion that the stepmother was trying to push the children into delinquency as a way of getting them sent off to a reform school! Again it is evident that there should be a search for symptoms in all four fields, and that the course of the difficulty is highly important. The highly specific nature of the inquiry regarding a given case and its crisis—the impossibility of formulating any routine examination that can be used with all cases—is evident.

History of the Individual

From study of the present difficulties one naturally proceeds, almost imperceptibly, to a consideration of the individual's life before the difficulty appeared. Again (as has already been indicated in the outline), there should be consideration of the medical, social, educational, and economic history. And again, both symptoms and course are to be considered; the development of the individual's nature, as well as his character at a particular time, is to be taken into account. For convenience, the development of the individual is to be considered as passing through three large phases: there is the person's childhood, his adolescence, and his adult life.

The Medical History. From the present crisis, one proceeds (if the case is an adult) to the adult life just preceding the crisis, and probably inquires first about the medical history. This inquiry usually leads back through the years of adolescence to the person's childhood and, finally, to the conditions of the individual's birth and any available prenatal history.

The questioning usually runs somewhat as follows:

(a) Has the individual ever had any physical diseases, or accidents? If so, what and when?

The examiner should ask especially about tuberculosis, acute infectious diseases, injuries and accidents, heart disease and arteriosclerosis, venereal disease, especially syphilis, excessive use of and susceptibility to the influence of alcohol and drugs.

(b) What are the individual's physiological habits?
Inquiry should be made into constipation or other digestive difficulties, appetite, insomnia, bed-wetting, general regularity of habits, susceptibility to fatigue, hypochondria.

(c) Has the person ever suffered from nervous or mental disease?
Inquiry should be made into "nervous breakdowns," periods of depression or excitement, attempts at suicide, episodes when the patient was "out of his head," dizziness or fainting spells, seizures or "fits," chorea, attacks of "hysterics," evidence suggesting delusions or hallucinations, actual hospital commitments or diagnoses of mental or nervous disease.

(d) Has the person been healthy sexually?
Inquiry should cover excessive masturbation, excess or frigidity, perversions.[1]

(e) Has the person's development been normal?
The examiner should investigate the health of the mother during pregnancy, nature of the birth, age of walking and talking, age of menstruation or pubescence, pregnancies (or miscarriages), age of menopause. The condition of a woman during menstruation, pregnancy, and menopause is especially to be inquired into.

Briefly, one should investigate physical disease, physiological habits, mental and nervous disease, sex health, and physical development. Anything of possible significance should be noted and the time determined when anything of importance in the individual's life occurred. . . . In some cases, more facts than those presented above will have to be gathered. But in most case studies the facts called for above

[1] An exceedingly important product of the inquiry here should of course be a determination of the individual's attitude toward sex matters, and the nature of his sex information. As will be emphasized later, unfortunate attitude and misinformation may be *the* important elements in a variety of abnormal conditions, and, of course, inquiry along these lines is peculiarly difficult; it must be searching and intimate and yet not morbid or suggestive.

will be more than adequate; this point will be further emphasized later.

The Social History. So much, then, for the medical history. In considering the social history of the "patient" another series of questions needs to be asked. These questions should cover the entire life of the individual as regards his relations with others, and should seek to determine any difficulties in adjustments to other persons. It should be mentioned, in this connection, that data regarding the social history of the individual are perhaps on the average the most important data collected in the case history. Where environmental factors have caused the mental difficulty, social maladjustment is found most frequently at the bottom of the trouble. And where the causes are to be considered medical the abnormal condition frequently shows itself first in social conflicts. It should further be understood that although the entire difficulty of a maladjusted individual may be social in origin, this origin may not be by any means obvious. Thus, when a sixteen-year-old boy learned that he was only an adopted child, the resulting emotional eruption ended in setting fire to the foster parents' barn. But the relationship was at first unsuspected, between this cause and the result. The cause of a difficulty may, in fact, be entirely social and yet the symptoms appear entirely in the medical history; thus the writers have seen many cases of middle-aged Jewish women who came into a clinic complaining of headaches, insomnia, and pains of various sorts, although the fundamental cause was maladjustment between the mother's "old-country" notions and her children's American ideas of conduct. The social history is thus exceedingly important in most cases; and it is often very difficult to interpret.

The important questions are, roughly, as follows:

(a) Is the individual's home life happy?
The examiner should ask about all the relations within the family, as between mother and father, brothers and sisters, husband and wife, parents and

children, other members of the family circle. Are there any marked antagonisms in the family, either between the patient and another member or between two other members? Is there a conflict of interests—does a boy, for instance, want to be a farmer, when his father insists he should be a lawyer? Is there, on the other hand, an over-indulgence of the child's whims? Is there some one in the family who completely dominates the patient's life to the stunting of his individuality? Is there any excessive attachment between the patient and some member of his family? Is the patient wholly passive in the face of either domination or attachment and willing that some one else should "run" him? Is the patient in conflict with the standard of the family, in some way? For instance, is the patient ashamed of the parents' manners, appearance, or speech? Especially, is there any conflict over religious matters and standards of conduct associated therewith? [1] Is there any outsider living with the family, as a boarder, roomer, distant relative?

(b) What can be found out about the individual's adjustment to other people, in his work? Inquiry should be made into his relations with employers, foreman, fellow-workmen, employees, business associates. The nature of any difficulty should be determined; there may be general irritability, dislike of a particular person, suspiciousness. Does he "mix" well with his fellow-workers?

(c) Has the school life been happy as far as personal relationships are concerned? Has the individual shown marked inability to get along with his teachers? Or has he been a "teacher's pet"? Has he been a problem of discipline in the school? And

[1] These last types of difficulty are very likely to appear among the children of immigrants when the children have been educated above the level of the parents. In manners, religious observance, and standards of conduct there is a painful clash between parents and child. It should not be overlooked, however, that in conservative American families holding strict religious views there are often equally painful conflicts—and this most often not over matters of belief, but rather regarding amusements and moral "taboos."

if so has he been malicious or merely mischievous? Is he avoided or disliked by other children? Is he laughed at? On the other hand, does he unduly dominate other children? Is he cruel to smaller children? How does he behave on the playground? (The testimony of a shrewd and observant teacher regarding a child's personality is exceedingly valuable.)

(d) What about the person's general social contacts?
The examiner should find out if the patient is generally sociable, a good mixer, and attends social affairs; a leader or a follower, an assertive or a timid person; seclusive and unwilling to mix with others of his own age and social status; ultra-religious, prejudiced, fanatical or radical on any matter. Special attention should be given to the individual's general emotional attitude toward others, as of inferiority (suggestive of an inferiority complex) or conceit and general incompatibility (which may, of course, be indicative of the same type of complex). Finally, there should be special consideration of the emotional life during adolescence.

(e) How about the individual's relations to the other sex?
The examiner should learn of irregular sex affairs, excessive flirtations or unusual sex-shyness, daydreaming about the other sex, prudery, or "crushes" with members of the same sex, or "Platonic" affairs with older people, general amount of interest in, and attitude toward, the opposite sex.

(f) Have there been any delinquencies?
Investigation should include truancy, running away, staying out nights, stealing, lying, early or excessive drinking or smoking, fighting or bullying, any actual crime or police record.

The questions concerning the individual's social life, in brief, should cover his relations with members of his family, with business associates, with teachers and schoolmates; it should also cover his general social relations, his attitude toward the other sex, and his delinquencies. Any matters of significance

should be traced back through adult life, adolescence, and childhood so as to obtain an idea of their development and source.[1]

The Educational History. The educational history is a much less complex and difficult affair. A person's achievement in school is, however, decidedly worth investigating, since it indicates his general efficiency, should discover any special aptitudes or disabilities, and predicts with some accuracy his probable future success in adult life. It should also be realized that (much more frequently than is generally known) failure or maladjustment in school is the source of emotional difficulties and attitudes which may operate pathologically even throughout adult life. So the investigator should try to determine the quality of the school work and the factors which influenced it.

(a) First to be considered is the main outline of the individual's school experience. At what age did he enter, and at what age did he leave, school? Did he attend regularly? Were there circumstances (such as frequent moving about of the family) which broke up the school work? Did the child fail any grades, or did he receive any double promotions?

(b) What, in general, is the individual's school achievement? The first point to be determined is the amount of schooling received; college, university, trade school, business school, night school, high school, and grade school training should be included. If the individual has not finished, or did not finish, the grades, note should be made of the last grade he was in. Did he do his school work

[1] It should not be supposed, from the large number of questions regarding the social history that have been suggested above, that an investigator should mechanically go through all these questions. The questions are intended to indicate the range of topics included under this general head. In any specific case the examiner must be guided by the nature of the problem, and the nature of the case, as to what he will ask. And the order and method of the asking will (as will be shown in a later chapter) depend upon circumstances.

well or poorly? A glance at the person's record card will usually answer this question.

(c) Has the school any information about the individual's ability, personality, or special interests? Was he ever given a test of intelligence? If so, what was the result? What did his teachers think of his ability? Did he show marked ability or disability along any special line? Did the school make any adaptation to such findings? Did he manifest any special interests, either in school work or in things outside the school? Such interests are important, as they may be utilized in adjusting the individual successfully. Is any estimate of his personality obtainable through teachers' estimates, remarks on his record card, or in any other way? Character traits shown in school are likely to persist throughout adult life.

(d) If the patient is still a school child, one further set of facts should be covered. What is his present educational status? What is his attitude toward his schooling? How long does he intend to remain in school? What are his educational plans, generally?

The educational history should thus cover the general chronology of the school experience, the amount and quality of the schooling, all information which the school can furnish regarding aptitudes and personality, and—where appropriate—present educational status and aims. If the case is a school child, evidently this part of the history is in the forefront. But in the study of adults, also, the school history is important, since it is the central activity of the individual throughout the most formative period of his life and since, moreover, it makes possible a more exact comparison with others of the same age than is possible at any other time.

The Economic History. If the case being studied is an adult wage-earner, an investigation of his efficiency in dealing with the total problem of making a living, and perhaps advancing his social status and preparing for the future, should be a central part of the inquiry. Even in the study of older

children information regarding any money earned may be highly illuminating regarding the youngster's character, and the vocational aim (or the lack of it) suggestive. It should be added that economic efficiency requires wise spending as well as adequate earning. It also should be noted that, in connection with this last function as well as otherwise, the housewife has an opportunity to indicate her economic efficiency.

(a) The first investigation in this field should probably be concerning the duties and conditions of the individual's work.
Inquiry should take account of the general level of work, as unskilled, skilled, executive, administrative, professional, and the conditions of work—the hours, the wages, the hygienic conditions of the place of work.

(b) Has the person been successful?
The facts especially to be noted are the financial returns, the number of times positions have been changed, the comparative standing with other men, or women, of the same age and occupation.

(c) What is the person's present economic condition? The examiner should find out if he is in debt, living beyond his means, simply living on his wages, "blowing in" his wages, saving his wages. The degree of prosperity or poverty should be noted.

(d) What is the worker's attitude toward his work? Is he content with his job? If not, what are the causes for his discontent? Is he making any consistent effort to improve his situation, as by further training, extra work, etc.? Is he willing to work overtime? Is he working toward some definite goal or is he simply doing his job from day to day? Does he seem to have any ambition, or pride in his work? Is he ashamed of his work?

(e) If the case is a child, especially if he is near working age, some attention should be given to his vocational aims. Has the child received any vocational guidance? From what sources? Does he have any real desire for any special type of work? Does the

child's vocational aim seem likely of fulfillment? That is, has he the ability, financial help, health, and so on, to carry out his desires? What work, if any, has the child already done to earn money? What use does he make of the money he earns? Have the people who have given him various odd jobs been satisfied with his performance?

In short, the individual's economic history should cover the nature and conditions of his work, his success and present economic condition, his attitude toward his work, and his vocational ambitions.

The schedule of inquiry regarding the history of the individual's medical, social, educational, and economic life will doubtless seem at first reading impossibly detailed. But it must be repeated that information with regard to all these points is relatively rarely obtained for any one case. For instance, a large number of the cases dealt with by the school official or personnel manager will require a modicum of all this information. In cases of any importance, however, it is desirable to determine something regarding each of the fields of inquiry; otherwise something of great significance may be missed altogether.

History of the Family

Selection simply of important topics is, of course, necessary in dealing with the history of the family. Sometimes inquiry about the family is simply a sacrifice of time to formal requirements of case study methods. But ordinarily something about the family is more worth while than too much detail about the individual. The writers are inclined to feel that too much emphasis has been put recently upon the importance of heredity as a determiner of both intellectual and moral traits. But even if one does grant that the hereditary factor has been overemphasized, it must still be allowed that heredity plus the influences acting upon the individual in childhood (particularly what might be called the social heredity of the family),

account to no small degree for what any individual is in adult life.

It must be emphasized that the family history is not all medical history, nor a matter of genetics. A very shrewd social worker once told the writers that the most illuminating single fact with regard to an individual was his father's occupation. It surely is important to know whether an individual's father was a professional man or a saloonkeeper, in understanding that person's moral and social attitudes and interests. And the general economic standard to which a man has been accustomed in his childhood is likely to determine, in quite large measure, the standard he sets for himself.

The inquiry with regard to the medical history of the family follows, in the large, the scheme used in investigating the medical history of the individual. In the medical history there is, of course, this difference, that diseases not hereditary, or accidents, have no significance (except as an accident to the father may have brought poverty to the family, or some such influence upon the family fortunes results), and the inquiry need not be as detailed. Investigation should cover the parents of the individual being studied, the siblings (brothers and sisters), and the person's children, if there are any. Further inquiry, as into side branches of the family, is not usually profitable.

Inquiry should proceed somewhat as follows:

(a) Are there any physical diseases that seem to run in the family?
The questioning should, of course, center around syphilis, tuberculosis, extreme alcoholism.

(b) Have any members of the family suffered from mental or nervous diseases?
Inquiry should especially take account of insanity, feeble-mindedness, epilepsy, temperamental peculiarity or queerness, suicide.

(c) Have any individuals of the family shown delayed or otherwise abnormal development? If any such evidence appears, regarding any members of the family, the inquiry should proceed briefly as sug-

gested in the questions on the development of the individual suggested in the previous section.

With regard to the social history the inquiry is somewhat more varied. The general social status of the family, and its place in the community, should be investigated.

(a) What can be found out about the neighborhood and the house in which the family live? The type of neighborhood not infrequently has an effect upon the manners and morals of the family; such terms as "good residential district," "tenement district," "slums," "business district," "suburban district," "foreign district," "'tough' district," "'red-light' district," and so on, may be used in describing the general milieu of the family. The kind of house, or tenement, is also significant. Is the house really large enough for the family? Is there reasonable privacy? Is it sanitary?

(b) Does the family show marked quarrelsomeness and irritability? Is there family dissension or incompatibility? Are any members of the family antagonistic toward each other? Is there argument constantly going on? Are there any feuds? Has the family been able to live peaceably with neighbors and maintain normal social relationships?

(c) Are there any definitely asocial individuals in the family? Has any one in the group shown sexual excess or abnormality? Has any member a history of delinquency or a police record?

(d) What is the general level of culture in the family? Is there reading matter around the house? If so, of what type? Is the family interested in music, art, or anything else of this kind? Do the family come together sociably at meals or does each member shift for himself? Are there family gatherings in the evenings for the pursuit of common interests?

Concerning the educational and economic status of the family even fewer questions will suffice. It is desirable, however, that some reasonably adequate general idea be obtained

regarding the family's general educational level and economic adequacy.

(a) What has been the general nature and level of the work in which the members of the family have been engaged?
(b) What is, and has been, the financial condition of the family? Some of the questions listed under a similar head for study of the individual might well be asked about the family in general.
(c) What, in general, is the educational level of the family? What is their present interest in, and attitude toward, education? Is there any attempt on the part of the family to interfere with the education of its members?

For the professional investigator the first warning regarding the family history is not to include too much! It should be kept in mind that the worker is studying the individual and *not* the family. An overconscientious social worker not infrequently gathers such a confusing mass of facts about the family of an interesting case that she loses track entirely of the important bearing which certain of these facts have upon the condition of the person she is studying. The purpose for which the family history is being gathered should be constantly kept in mind; and only such facts should be investigated as seem likely to have a bearing upon the present problem.

The chapter has, thus, dealt with that usually most important part of the study of any individual, the study of the "history." (1) The essentials of a case history were first outlined. (2) Next, suggestions were given regarding the gathering of information about the present crisis—that is, about the particular circumstances (mental disease, delinquency, failure in school, chronic lack of self-support), which have made the investigation necessary. (3) Following this were detailed the numerous topics to be covered, for an

adequate understanding of the individual's previous life. (4) Finally were indicated those facts about an individual's family which were needed as a background for insight into his personality. It was shown that regarding the present crisis, the history of the individual, and the family history, information medical, social, educational, and economic, was needed. . . . A discouragingly elaborate program, it would appear. But a little trial experience in "history taking" will prove it to be fascinating work, giving a new appreciation and understanding of a host of social, economic, and educational problems.[1]

As illustrative of the use of the outline described in the preceding pages, the writers are presenting below two case studies. It should be noticed that in neither of these studies are facts given under *every* point in the outline; there was nothing of importance to give, though inquiry was made on all major topics. The outlines, nevertheless, contain sufficient facts to make the history quite clearly indicative of the probable diagnosis. They illustrate, at the same time, the flexibility of the outline and the importance of the case history.

The two cases are very different indeed in the investigatory problems they present. The first (and a common type of case), illustrates a situation where adequate data, careful judgment, and good sense are especially necessary—and these qualities especially often lacking! The girl was certainly not feeble-minded, though in an institution for the mentally defective. She certainly showed no symptoms of frank mental disease, and hardly enough mental abnormality to be put in the "borderland" group. The girl is probably best considered mentally within the "normal" group, and to be thought of as primarily the product of vicious home and neighborhood environment. For understanding of such cases a full and carefully studied case history is vital. The second case is a straight case of manic-depressive insanity. The predominance of social factors in the first study, and the comparative lack of them in the second, should be noted.

[1] The outline as given in this chapter, together with topics to be mentioned in the chapter following, will be found conveniently arranged for case-study work in the Appendix.

Case Study of a Delinquent Girl

Name: Elsie F. *Age:* 18. *Sex:* Female. *Race:* White. *Birthplace:* New York City. Single. *Sources of information:* girl's own story, mother, probation officer, policeman, court record, principal of grammar school, vice-principal of high school, head of ribbon department in store, institution record, institution officials.[1]

I. History of the Family.
   A. Medical—Mother has syphilis. Two younger children in the family are feeble-minded (probably syphilitic) and now in an institution (I.Q.'s of 63 and 54).
   B. Social—Family very delinquent. Family live in a two-room flat in a district of tenements, cheap hotels, and disorderly houses. Mother is suspected of contributing to the girl's sex offenses and of being immoral herself. Father has criminal record showing a number of small offenses. Two brothers of the girl have been in reform school.
   C. Educational—The younger children have not been able to complete the fourth grade (at ages of 12 and 15). The three older members of the family completed the eighth grade, and two of them went through one year in high school.
   D. Economic—Father works only occasionally at odd jobs. Brothers have been self-supporting, but by illegal means (involved in drug-peddling). The family has received aid from several social agencies during the last few years.

II. History of the Individual.
   A. Medical—Walked and talked a bit late—at 1½ and 2 years, respectively. Has recently contracted venereal disease which has not been treated.
   B. Social—Girl has always been wild and difficult to control. Has had the reputation (in school and in her neighborhood) of being immoral since early childhood. She says her mother never made any effort to keep her from such affairs, and that her mother is a prostitute. Has played truant from school to go on "sprees," usually with older men whose names she either does not know or will not tell; since she left school at 15, these delinquencies must have begun early. Has been out on the street at night regularly for the last two or three years. The policeman in the district gives her a very bad reputation, saying that she is not only immoral but frequently disorderly.

[1] Such data as the names and addresses of these informants should, of course, appear in the actual case record, but obviously need not be published here. For the nature and arrangement of such supplementary information see the Appendix, and also Chapter IV.

C. Educational—Finished grammar school and stayed a year in high school. Work above average, though not especially good. Was not failing when she left school, but was making even more trouble, breaking school rules, than usual.
D. Economic—Worked at a ribbon counter in a large department store. The work she did was satisfactory, but she was "fired" after five months for general "toughness," for getting into arguments with customers, and for being a bad influence among the other girls. Has been on the street ever since.

III. History of the Present Crisis.
A. Medical—Has venereal disease.
B. Social—It became known in the district where she "worked" that she had become diseased, so she went across town to the railroad yards to start over again in a new place. She had no money and had been unable to borrow any from her family. Being desperately in need of money (she couldn't get anyone to rent her a room since she had neither baggage nor money) she started work too soon, before she knew the district, and was caught by a policeman and arrested as a public nuisance. She was brought before the court where it was found that two younger children of the same family had recently been committed to a school for the feeble-minded, so she was also committed by the court, without an examination, upon the assumption that she, too, was mentally defective.
C. Educational—None.
D. Economic—Crisis precipitated through her diseased condition, since she was forced to change districts.

Case Study of a Man with Manic-Depressive Insanity

Name: John S. *Age*: 34. *Sex*: Male. *Race*: White. *Birthplace*: Iowa. Married. *Sources of information*: own story, wife, employer, hospital record from previous admissions, mother, maiden aunt, family doctor.

I. History of the Family.
A. Medical—Grandfather and one uncle committed suicide.
B. Social—Average, middle class family. Fairly active in Methodist church. Father belongs to a lodge, but is not prominent. No abnormalities.
C. Educational—Parents had grammar school education. A younger sister of patient is in high school.
D. Economic—Patient's father was a carpenter.

II. History of the Individual.
   A. Medical—Has had periods of depression when he would sit about the house doing nothing but occasionally talking about his sinfulness. These periods began during adolescence, and have been of varying degrees of seriousness. About six months ago he had an attack of excitement—talked constantly for several hours, did not sleep for three nights, walked up and down the floor, was irritable when spoken to; there seemed to be no particular reason for this excitement, nor did his constant talking betray any special ideas on which he might be centering. Patient has been in an insane hospital twice with periods of depression, and was in a "nursing home" during the recent attack of excitement.
   B. Social—When depressed becomes very religious and critical of others. Is usually kindly and pleasant, however. Is liked by his business associates, fond of his home and family.
   C. Educational—Is a high school graduate. Did average work in school.
   D. Economic—Is a traveling salesman; fairly successful. His firm says he makes friends wherever he goes. He is valuable enough to them for them to take him back after each of his episodes and to pay him half his salary while he is away.

III. History of the Present Crisis.
   A. Medical—Became exceedingly depressed about a week ago. Complained of being tired and discouraged, though there seemed no cause for discouragement. Began to refuse food, and has lost about 15 pounds. For the last week has hardly slept at all, but has walked up and down his room, or else sat motionless in his chair. Has been extremely constipated; this condition was not relieved by ordinary physic. Two days ago he attempted suicide by turning on the gas in the bathroom, and was sent to the hospital for observation. The only reason he can give for his suicidal attempt is a vague feeling of sinfulness, of despair, and an extreme fatigue.
   B. Social—Has been very seclusive during the last few days; sent visitors out of the room; refused to talk with his wife. Has spent most of his time, day and night, sitting in his room staring at the floor and sometimes praying, sometimes crying, occasionally wringing his hands.
   C. Educational—Nothing.
   D. Economic—Stopped work on the first day of the attack, and has been unable to make the effort to resume it since.

CHAPTER III

THE STUDY OF THE PRESENT CONDITION

It will be noticed that thus far the study has been concerned only with the events leading up to and occasioning the present study of the individual. These events may well be more important than any symptoms now displayed, in explaining the individual's difficulties; but they were, nevertheless, gathered primarily as a means of obtaining light on his present condition. It will also be noticed that nothing has been said, thus far, about methods of examination. So far, presumably, there has been no examination of any systematic or reliable sort. The facts of the history have probably been gathered partly from the patient, partly from relatives and friends, employers or fellow-employees, the police, chance passers-by—in any case from individuals not trained in the study of mental peculiarity, and usually highly unreliable or prejudiced sources of information. The case history is thus a history of the patient as he has been, not as he is; and it gives facts about the case reported by witnesses of an unknown, and frequently unsatisfactory, trustworthiness. In contrast, the present chapter deals with the individual as he is now, and as observed by persons who are (presumably) especially trained in the study of mentally peculiar individuals, and capable of duly describing, appraising, and interpreting whatever symptoms may be observed. This twofold distinction—that the history is of past happenings and hearsay or secondhand report, while the mental examination deals with the present condition and is the result of skilled investigation—is decidedly important.

The Essentials of a Study of the Present Condition

A complete study of the individual's present condition should obviously include consideration of both physical and mental symptoms; there should be both a physical and a mental examination.[1] The nature of the physical examination need here be only roughly indicated. A complete physical examination by a physician is usually desirable whenever this is possible. But such an examination is often impossible—frequently it is not called for. Whatever information is obtained about the patient's present physical condition must, then, be gleaned by the investigator through more or less incidental observation and questioning. For guidance, in this last contingency, the non-medical investigator certainly needs a rough outline and some general suggestions with regard to matters most deserving inquiry.

The outline for study of the present mental condition is also very simple. It is, in fact, concerned more with the form of record than with the procedure of the actual examination. The actual examination must usually proceed according to the exigencies of the occasion. It must be definitely understood that no outline must be allowed to hamper the natural progress of an interview, or operate to confine the inquiry to a few short questions.

It need hardly be added that the study of the present condition of the case may be made under widely varying circumstances. The examination may go all the way from a very incidental conversation and shrewd estimate to an elaborate

[1] It should be reiterated that for many purposes the majority of the information mentioned will not be needed. Thus a school official will sometimes obtain no more information regarding physical condition than comes with somewhat casual observation. And a majority of what is said regarding the mental condition will be irrelevant. *The material is to be read selectively with reference to the reader's needs.* The presentation is rather full, because for some practical purposes such an elaborate study of the case is needed, and because the general reader should appreciate the wealth of information required, for a total appraisal of the individual. But the reader must be on guard not to be confused by detail. The outline has been very carefully worked out, and if kept constantly in mind will prevent such difficulty.

investigation of different types of memory, association, emotional trend, and so on. A social worker may interview a case in the quiet of her office or in the midst of the distractions of the patient's own tenement home. The court investigator may never know his case until after sentence has been passed upon him; or he may have the happy opportunity of long confidential talks with the offender before he appears in court. The employment manager is perhaps most likely to suffer from lack of opportunity to study his men in any detailed fashion; but occasionally he may be able to study some individuals for months, in an intensive but unobtrusive way.

The following general scheme has been found by the writers of suggestive value in the examination, and of distinct service in organizing and summarizing the record of an examination.

IV. Present Condition.
- A. Physical Condition.
  - General Health.
  - Special Defects.
- B. Appearance and Behavior.
- C. Intellectual Condition.
  - General Level.
  - Special Functional Disorders; as in judgment, attention, memory, association, perception.
- D. Emotional Condition.
  - General Tone.
  - Special Emotional Trends.
  - Emotional Conflicts.

It must be noticed that this outline is not independent of the previous outline given for history taking, but is a continuation of the case-study outline. It is the fourth and last main topic, and is correlative with "History of the Family," "History of the Individual," and "History of the Present Crisis."

The Study of the Physical Condition

General Health. In considering the physical condition, as a matter for study in connection with study of the individual's personality, problems, and difficulties, the natural first ques-

tion is: Has this person any outstanding organic disease? It is obvious that an individual may be a social problem because he is a victim of tuberculosis or neurosyphilis. It should also be understood, by those whose business it is to study individuals who are mental problems, that physical disease very frequently reacts upon the personality. The effect of tuberculosis is fairly well known. Diabetes has its mental as well as its physical symptoms. The various infectious diseases may cause acute mental upsets, from which the patient recovers very slowly, or they may initiate a morbid mental condition (previously latent in the patient's personality), which continues after the physical disease has disappeared. The possible presence of such disease must, then, be investigated wherever there is any suspicion of such factors. It must be remembered, further, that more or less obscure physical conditions may often exhibit themselves in part by peculiarities of temperament, or even more serious nervous and mental difficulties. Thus, focal infections, as of the teeth or tonsils, may be of distinct importance here. Such matters cannot, of course, be dealt with by the social worker or clinical psychologist. It is the part of the present text only to emphasize the importance of such factors, and to urge a thorough medical examination by a competent physician wherever this is possible.

A variety of physical diseases may, then, have mental by-products of a more or less serious nature. Certain physical diseases are, however, of outstanding importance as affecting often primarily the nervous system and causing mental abnormalities of the most profound nature. First to be mentioned here is syphilis. It might almost be said, categorically, that the presence of syphilis is always to be considered where there are evidences of mental peculiarity. A history of syphilis is usually difficult to obtain. But, fortunately, the Wassermann reaction makes possible the determination of the presence of the disease with a high though not absolute reliability, and the laboratory findings with the spinal fluid give information

of practically a final character with regard to neurosyphilis. Diseases of the circulatory system, as hardening of the arteries, perhaps deserve next mention. Abnormal circulatory conditions may be determined by palpation of the arteries, examination of the blood pressure, by the heart sounds; it must be always remembered, however, that there may be hardening of the cerebral arteries without sclerosis elsewhere. Finally, any disorder of the thyroid or other ductless glands is likely to be of great importance, in children or adults. . . . It is obvious that a physician's report should be carefully studied, with reference to these matters.

The investigator should also note any neurological symptoms that appear in the physician's report. Absence of knee-jerk at once leads one to suspect some morbid neurological condition; a number of diseases may so operate, however. Failure of the pupils to react to light or partial reaction with irregular pupils also is similarly suggestive,—is probably syphilitic or perhaps alcoholic, or possibly of more obscure origin; a "positive Romberg" (swaying or falling when the feet are placed together and the person is asked to stand with the eyes closed) has much the same significance. Other reflexes may be reported, and should be understood, at least so far as their significance regarding the presence of morbid nervous conditions is concerned, by the investigator.

Symptoms such as have been enumerated in the past two paragraphs can be obtained, of course, only from the report of a physician; but there are certain other symptoms, of a more general nature, that may or may not appear in a medical report, but may be observed or inquired after by the worker.

Such symptoms are: general evidences of malnutrition or underdevelopment; marked flabbiness of features, pasty complexion, expressionless features, or partial facial paralysis; cold, clammy hands, cyanosis; ataxic gait, a putrid breath, speech defects (or defects in writing), marked evidences of senility, evidences of alcoholism, twitching, any gross physical abnormality. All such matters should be carefully observed

and made note of. Inquiries should be made as to constipation, dizziness, headaches, loss or increase of weight, and so on (as mentioned in the section on the history), and should be noted here, if these symptoms appear to be factors in the present condition.

Special Defects. The examination should not be by any means confined to such symptoms of active physical disease, however; any physical defects, deformities, or peculiarities should be carefully taken account of. Defective or peculiar mentalities are likely to be associated with bodily defects and peculiarities. Besides, physical defects are sometimes the center or nucleus of the mental difficulties from which the patient is suffering, and should always be considered if the worker is attempting to fit the sufferer to a new environment.

Certain stigmata—ordinarily called the "stigmata of degeneracy"—can usually be easily observed. Such defects are: facial asymmetry, harelip, protruding or malformed ears, facial grimaces, strabismus or other eye difficulty, high, cleft, or missing palate, deformities of the nose, irregular and impacted teeth. Peculiarities in the shape of the head, malproportioning in the general physique (such as unduly long arms or legs), gigantism or dwarfism, extreme awkwardness, are all worth considering. The stigmata are probably not as important as was once thought; certainly some of the stigmata, such as protruding ears or impacted teeth, are common enough. But if an individual possesses several prominent stigmata he is very likely to have mental defects as well.

It hardly need be said that such marked sensory deprivations as deafness or blindness are both important in themselves and suggestive of more fundamental diseased conditions correlative with mental defect. In any case, a blind or deaf person presents a social and occupational problem. It should be emphasized, however, that relatively slight sensory defects (such as slight deafness or extreme near-sightedness or astigmatism) are often not recognized as such, but instead handicap the individual in such a way as to suggest mental retarda-

tion. It is really not at all difficult to test both hearing and vision in a rough way, and almost incidentally, in the course of an interview. The investigator must not make the kindly mistake of attributing mental dullness to poor eyes and ears, however; the illiterate scrub-woman who cannot read "because her eyes are so poor" is not uncommon in a mental clinic.

Appearance and Behavior

So much regarding an individual's physical condition. What data are to be obtained regarding the main subject of the inquiry, his personality and general emotional and intellectual status? We will suppose that a physical examination has been made, has not been obtainable, or has been dispensed with—that anyhow the case is now appearing for an interview with the investigator (psychologist, social worker, personnel manager) who is attempting a diagnosis of his "personality." What information does this investigator gather?

In the interview, a person's *appearance and behavior* are evidently the first things to be noted. Almost as soon as the interviewer sees his subject he begins to form some opinion about him. The individual's general bearing, his manners, his clothes, and his actions during the interview all contribute to an understanding of the case and are of importance in deciding what can be done for and with him.

Is the individual restless, nervous, or fidgety? Does there seem to be a press of activity? Or, is he slow, hesitant, lethargic? Does any activity appear to be made only with effort? Is he impulsive, jerky, or odd in his movements? Has he any mannerisms or peculiarities of speech or action? What about the person's general bearing? Is he boisterous, overconfident, confidential, furtive, diffident, reserved? How does he shake hands?

How is he dressed? Are his clothes "loud," extravagant, "showy," or bizarre? Is he neat, in good taste, careless, shabby, dirty, or ragged? Are his manners affected, refined, pleasing, crude, rough, vulgar, familiar? Does he appear

wealthy, well-to-do, self-supporting, poor, poverty-stricken? What is his apparent occupational level?—laborer, artisan, clerk, professional man, independent business man, or does he belong to the group of the "unoccupied"—clubman, roué, crook, gambler, hobo, ne'er-do-well, loafer?

It is obvious that, in many cases, there may be nothing to note in regard to many of these points just mentioned; it is also evident that appearances are sometimes deceptive. But, from the point of view of the characterologist, the deceptive appearance is even more material for thought than the greatest obviousness. A careful observation of the individual's appearance and behavior will often give a clew to the mental condition; it is always of importance. And it is well to remember that the investigator will surely receive an impression of some kind, and it is better if the impression be distinctly "labeled" as such, so that the investigator will not confuse his intuitions with his knowledge.

The Study of the Intellectual Condition

After the preliminary greeting (supposing the physical examination to be either completed or to be done at some other time) and the first swift glance of appraisal, the interview itself begins,—or rather, if the interviewer be skillful, the subject is carried, without knowing it, into the real interview. The interview will probably begin with sympathetic questionings about the present crisis, will doubtless proceed to the history of the individual and family history, and will then, if there be suspicion of mental disease or peculiarity, involve a more or less explicit questioning with regard to the person's general mental condition. As a matter of fact, no two interviews are alike; the nature of the interview depends upon the nature of the problem, the personality of the subject, the circumstances under which the interview takes place, and so on. These factors are of such importance that the next chapter will be devoted entirely to a consideration of them. But anyway, whatever the exact procedure, the interview must almost

of necessity yield more or less information with regard to the individual's *intellectual condition.* And the natural procedure here is to consider the individual's mentality first somewhat analytically, and then to come to some conclusions regarding his total mental capacity or general level of "intelligence." [1]

Judgment. First of all, it is important to learn something of the individual's judgment, his conception of things, his general ideas about himself, and his environment. The question is as to the general organization of the individual's ideas —the way in which he puts two and two together. A judgment in this sense is not, of course, a reasoned conclusion, but rather one's belief or taken-for-granted attitude about things. To make a simple, but rather helpful, classification, it may be said that three types of maladjustment in this field are possible. (1) The person's ideas may be overorganized; all his ideas are centered about some one matter. His mind is completely taken up by some grievance, some ambition, some fear or anxiety; all his judgments and inferences are made with reference to this one dominating idea. A person of this type is usually called a fanatic.

Any idea may, of course, thus function. An example (which is admirable) of this type is the man who is altogether wrapped up in his family. But such a man hardly constitutes a social problem. The social worker may come in contact with individuals of the criminalistic sort who seem to be motivated largely by an animosity toward society in general. The individual who is overwhelmed by grief or disappointment and tries to drown his sorrows in alcohol or drugs may also be seen occasionally. Persons who are over-cleanly, the "food-faddists," and the hypochondriacs, are all overorganized toward some one idea or set of ideas.

The person who thinks too much about his grievances, his sins, or his diseases does not ordinarily, however, come in con-

[1] In the record form "general level" appears first since in going over a record form one naturally wishes first of all information as to the general capacity of the individual.

tact with psychiatrists or social workers unless there is the further important difficulty that the idea by which the individual is governed is false, that (2) he is deluded. The individual then attempts to revenge himself not for a real insult but for one that is fancied, or attempts to commit suicide because of vague, unmentionable sins that were never committed, or insists that he is dying of some strange disease of which he has not the slightest symptom. These are, of course, delusions; and it is obvious that from a practical point of view delusions are perhaps the most important single symptom of a diseased mental condition, since they put the individual at odds with things as they are. That is, delusions are fundamental mistakes of judgment and may lead to dangerous and anti-social acts.

A third (3) defect of judgment is possible,—no judgment at all! The individual's thinking is not coördinated. In everyday life we frequently see the scatter-brained person, of intense but brief enthusiasms, the helter-skelter person who runs from one thing to another, who is inconsistent, irresponsible, and unreliable. This type is seen in exaggerated caricature in the manic phase of manic-depressive insanity, and in mild intoxication. A total disorganization, frequently accompanied by fleeting delusions, appears in delirium.

Information with regard to the individual's mental organization will naturally emerge in the course of the history taking. For instance, the individual has a grievance directed against his foreman, which information from other sources shows to be entirely unfounded and which the individual maintains in the face of these facts by other erroneous statements, more fanciful still. The man is evidently deluded. These deluded cases are, of course, by all means the most important type. A borderland case is given by the individual who has been with a prostitute for the first time, has become remorseful, and is now certain that he contracted syphilis. Repeated negative Wassermann's fail to reassure him; he is certain his specimens have been mixed up with some one else's or that some similar

mistake has been made. Such cases are excellent examples of the domination of an individual's entire mental life by one idea, which at first appears reasonable but which persists into a hypochondriacal delusion.

Attention. Very naturally in the course of the interview, and as a matter clearly connected with the topic just treated, one obtains some notion of the individual's ability to concentrate, to keep his mind on one topic, to think consecutively, to control and direct the progress of his thinking. A morbid concentration of attention on one topic to the exclusion of all others appears in the morbidly despondent individual who thinks of nothing but his sinfulness and the punishment that is in store for him, and is oblivious to those about him, replying to questions not at all or only after repeated efforts have been made to gain his attention. At the opposite extreme is the manic who is incapable of even so brief a period of concentration as is required to write his name, but stops halfway through his signature with a long flourish and turns to something else, only to leave this new object in turn for another novelty. This sort of thing is evident in less vivid form in the garrulous senile who talks interminably without ever reaching the goal he starts for. A third disorder in the control of ideas appears in that strange group of phenomena comprising compulsions, phobias, obsessions, and so on. The individual's attention is fixed in spite of himself upon the dreaded object or act. The idea will not leave his mind, try as he will to turn from it. The patient feels himself compelled, as by some force from without, to do or say what he does not wish to say or do. That is, there is not an extreme concentration of attention; the ideas are not, to an extraordinary degree, controlled and directed toward one idea; nor is there simply lack of control and dissipation of attention. There is, instead, a strange perversity, or inability to control the progress of one's thoughts.

Memory. Almost inevitably, in the course of the interview, one forms some opinion of the accuracy, vividness, and detail

with which the individual retains ideas,—of the patient's memory. All the facts about the patient's personal and family history, and symptoms of the present trouble are, of course, simply so much data in regard to the patient's memory. If any peculiarities of memory are suggested, in the course of the interview, more detailed information with regard to the matter may be obtained by specific inquiry along these lines. Detailed questions may be asked about the individual's childhood, about events since then and about recent events, to determine whether there may be any loss of memory for remote or recent events, any gaps or peculiarities in the person's total recollection of his life.

Simple questions, to test the retention of early facts learned in school, are usual. The patient may be asked to name the longest river in the United States, or to give the name of the president during the Civil War; or he may be tried on simple arithmetic. The individual may also be asked where he lived during certain periods, who his playmates or companions were, or what he did. Such questions as these may throw light upon the patient's social history as well. At the other extreme, inquiry may be made as to such very recent events as the patient's breakfast or the events of the day before. Memory of the most immediate type may be investigated by saying over six or seven numbers and having the patient repeat them, or having the subject read a brief paragraph in a newspaper and then tell what he has read.

The most common memory disorder is, of course, amnesia, or less of memory; such loss may, it need hardly be said, be of various types, affecting practically any set of events in the patient's life,—whether remote or recent. There may, however, be an exaggerated vividness and completeness of detail, as in some types of mania; the patient is able to tell to the day, hour, and minute when he was admitted to the hospital, who admitted him, and all the other circumstances connected with that event. Or there may be a falsification of memory. The patient, without realizing it, fills up gaps in

his memory with details which he imagines are true, but which may be ludicrously incongruous with the real facts.

It is, of course, not always easy to decide what a person should or should not remember. The "standard" of memory is a thing that only experience can settle. After one has taken a few case histories, one insensibly arrives at a fairly definite standard as to what a person should be able to recall about his past life. Not too much should be expected in the way of retention of school knowledge. Perhaps the investigator himself could not, offhand, tell his exact age when he graduated from grammer school, or other similar details. But certain of the most prominent bits of school information should be recalled. It is also necessary to realize that the day laborer is less likely to remember facts taught in school than is the educated person; the latter has had the facts presented oftener and more recently; the former has drifted into work in which these facts do not function, and has lost any interest he ever had in school work. So allowances must be made; but any deviation of memory from what should be normal for the individual should be carefully noted.

Association. The detection of any marked peculiarities in the flow of ideas is usually fairly easy. A depressed person usually shows a retardation, or slowness, in the flow of ideas; he speaks slowly, answers questions only after a pause, appears even to have forgotten or not to have heard the questions, but finally makes a perfectly relevant reply. The manic case, on the other hand, is troubled by a press of ideas. He talks rapidly, answers questions almost before they are asked, hurries from one topic to another with scarcely any pause for breath. A dementia præcox case shows a third fault of association by replying with peculiar bizarre statements apparently under the impression that he is answering sensibly. He employs unusual words, may insert totally irrelevant words in the middle of a sentence. Or, successive sentences may show no recognizable connection whatever.

Here, as elsewhere, it must be kept in mind that individuals

who are not mentally diseased or even strikingly atypical may, nevertheless, show marked deviations from what one ordinarily considers normal. The naturally phlegmatic individual is always more or less "retarded." An excited Italian on a holiday shows almost "flight of ideas"; many excitable people show a great press of ideas, coupled with rapid talking and considerable over-activity, as their normal condition. Irrelevancy is by no means confined to the insane. There is, of course, no definite line of demarcation between the normal and the abnormal. In judging as to whether or not a person is now suffering from a disorder of association, it is always desirable to compare his present state with *his own* normal condition. Any change, from what has been, is significant.

Perception. A word remains to be said about disorders of perception. In dealing with a normal or borderline case, nothing whatever in the way of disorders of perception will usually be found. But if acute mental disease is suspected, the possibility of hallucination must be considered. Often, evidence of hallucinations will appear in the course of the history taking; the subject complains of voices threatening him when no one is about, or he sees strange faces at the windows, or feels electric currents coursing through his body. In other instances, however, evidence of such hallucinations may not appear except after the most careful and cautious questioning. If a person knows he is hallucinated he will usually avoid any mention of the fact for fear of being thought insane. Under such circumstances, the most sympathetic and tactful inquiry is necessary regarding all that is troubling the patient, if he is finally to confide to the investigator his anxiety about the voices, visions, or unnatural feelings that disturb him. Whenever real hallucinations appear, it may usually be taken for granted that the individual is suffering from some form of serious mental disturbance—that he is psychotic or "insane."

There are two other disorders of perception sometimes found, but these will more likely appear in the report of the physical

examination. Cases showing stupor are, of course, more or less anæsthetic; but the anæsthetic conditions of which the investigator should especially take account are either the blunting of all sensation appearing in dementia or organic brain disease, or the functional anæsthesias appearing in hysteria. The hysteric may, for example, show no sensitivity whatever to pin pricks in certain areas of the body. At the other extreme, these same hysterics may show a morbid oversensitivity to pain, touch, sights or sounds. This hyperæsthesia may also occur in manic cases. The patient cannot bear to be touched. And it appears as if there were an actual increase in acuity, so that sounds not noticeable to the average person may be heard; or type too fine to be easily read by the patient when in a normal condition is now read without the slightest difficulty.

Study of the intellectual condition may thus be said to involve consideration of the individual's judgment, or organization of ideas; of his attention, or control of his ideas; of his memory, or retention of ideas; of his association, or flow of ideas; and of his perception, or intake. And it is of interest to consider in each instance the possibility of over-functioning, under-functioning, or perversion of function. The analysis in many, if not most, cases may not be carried through in any such explicit fashion; but even in the study of a feeble-minded school child it is often helpful to run over this list of functions in summarizing one's conclusions from an interview.

General Intellectual Level. In work with a subnormal child, the major consideration is not as to special functions but as to the total ability, or general intelligence, however. The interviewer's conclusion with regard to the child's general intelligence will be based in part upon the total of the considerations so far indicated. But certain special methods should ordinarily be used. In particular, a test for determining general intelligence should presumably be employed—given to the case either by the person conducting the interview or some one else competent to do this work.

The test by all means most commonly used is the Stanford Revision of the Binet Scale. This consists of a graded series of some seventy-four little problems (plus certain supplementary tests) beginning with very simple tasks such as (for three-year-old children) "Show me your eyes; show me your nose"; or "What is your name?" and the naming of familiar objects such as a key, pencils, pocketknife. Farther on in the test are harder problems which include the repeating of series of five digits from memory after the series has been read once (Year 7), definition of abstract terms such as "charity" and "justice" (Year 12), or finding the moral taught by a fable (Years 12 and 14). For the older children such complicated tasks are required, as mentally rearranging the hands of a clock ("It is now 2:15; what time would it be if the hands of the clock were reversed?")—(Year 16), repeating a list of six digits in reverse order from that in which they were read (Year 16), or summarizing from memory a complicated passage dealing with abstract ideas (Year 18). Roughly the individual's level of intelligence is determined from the number of problems he can do successfully. That is, roughly, if the individual does as many tests as the average ten-year-old child he will be said to have a "mental age" of ten; if he passes only a few tests—about the number passed by a four-year-old child—he will be credited with a mental age of four. If the individual is chronologically ten years old, but scores no better than a four-year-old child, he is evidently distinctly below normal in intelligence, according to the test. In terms of per cent, he is only 40% of what he ought to be. That is, he has an "intelligence quotient"—or I.Q.—of 40. On the other hand, a bright ten-year-old child might solve so many problems that he would gain a mental age of 14. His intelligence quotient would then be 140. These terms, "mental age" and "I.Q.," should be understood, since they frequently appear in case study reports, particularly of school children and delinquents.

There are, of course, other tests of intelligence which may be used instead of the Stanford Binet; but in study of individual cases this scale is by all means the most frequently used. In many instances (especially in the schools) the results of group tests of intelligence may be available, however. These results may be given in various forms, but most commonly here also in terms of mental age.[1]

[1] The whole subject of intelligence tests and their use is evidently too special (and also too complex and controversial) for further discussion

Such tests must be used—with intelligence! It should be obvious that if the case does not speak English readily, is physically ill, or emotionally very upset, the findings cannot be trustworthy. But if the tests are given with skill, and interpreted with reasonably good judgment, they help a great deal in determining the individual's general mental level.

It should be evident, then, that test results cannot be used in place of good judgment about an individual; interpretation of test results requires no little experience in such work. The individual referred to a moment ago who was ten years old but had a mental age of four and an I.Q. of 40 (and who was of English-speaking parents in good health, and as coöperative as such an imbecile could be) was diagnosed as feeble-minded with comparatively little difficulty. But another child, also ten years old, but with a mental age of seven and I.Q. of 70, was considered simply a dull individual. He could not properly be called feeble-minded, in view of this score plus consideration of the fact that he had just been arrested for breaking windows and was somewhat sullen and uncommunicative. Interpretation of test results with reference to the diagnosis of feeble-mindedness will be returned to later, in the discussion of the mentally defective.

The Study of the Emotional Condition

Data regarding the emotional make-up of the person interviewed are usually the most important data of all. Lack of emotional control is obviously the fundamental factor in many criminal acts and in many problem cases in school and shop. Emotional perversity is the factor in another type of criminal case. Lack of adequate emotional appre-

here. For a general treatment of the subject see Pressey, S. L. and L. C., *Introduction to the Use of Standard Tests*," Part III, World Book Company, 1922. An elaborate statement with regard to the Stanford Revision, with directions for use, will be found in Terman, L. M., "*The Measurement of Intelligence*," Houghton Mifflin, 1916, and an excellent summary of work and findings in this total field is to be had in a recent book by Pintner, "*Intelligence Testing*," Henry Holt and Co., 1924, p. 406.

ciation of the nature of the criminal act and its consequences may be considered the fundamental feature in many of the cases remaining. Further, emotional conflicts or peculiarities may be considered at the bottom of various borderland neurotic and psychopathic conditions. And the functional psychoses seem to be characterized most definitely by pathological emotional states. All these conditions usually come to attention first in school; some originate there; very many could be constructively dealt with there if means and understanding were adequate. In short, a study of the individual's emotional make-up is all-important, for court worker, employment manager, social worker, *and* school official.

This side of the individual's personality is also, in many ways, the most difficult to get at. Much must be worked out from the history. Some relevant facts may be obtained from members of the patient's family or from friends. Little can usually be obtained from a direct questioning of the individual. But a great deal may be learned from shrewd observation of him in the course of the interview.

General Emotional Tone. First of all, the investigator should note if the case appears generally overemotional, apathetic, or silly—emotionally peculiar. The manic case will be easily aroused to anger or any other active emotion. The depressed case is sunk in the depths of hopelessness and despair. Either of these individuals shows an abnormal condition chiefly characterized by pathological excess of emotion. The demented person shows an incapacity for any feeling or emotion whatever. The incipient dementia præcox shows a peculiar silliness—a tendency to laugh at the serious, or to giggle and smirk at nothing at all. There is a complete divorce between the incident and the emotion aroused; and the emotions thus aroused are seldom very profound. The feeble-minded may show excitability, more often are simply apathetic—emotionally dull and sluggish.

Questioning aiming at the determination of these conditions should, of course, be questioning regarding emotional inci-

dents in the patient's life. These will, for the most part, be touched upon in the course of the interview. They need only be played up and recurred to, if more opportunity to observe the patient's emotional reactions is desired. Direct inquiry should also be made as to whether the patient is habitually despondent or happy-go-lucky and inconsequential. What is his judgment as to his present mood? Is it different from his ordinary mood? Does he understand it? It is especially important to consider any present emotional symptoms in their relation to the patient's history.

Special Emotional Trends. The individual may show primarily, however, some special emotional trend. A child may show, as a dominant characteristic, extreme timidity. Work in school and activity on the playground may be largely inhibited. The child recites only when called upon, in a low voice and with great diffidence. On the playground there seems to be fear of other children. Or, the attitude may be suggestive more of worry. There appears to be some anxiety to which the individual's mind is chronically turning, with resulting interference and inefficiency in anything which the individual may undertake. In such cases there should be a sympathetic and tactful attempt to get at the sources of fear or worry. Such difficulties may start with some particular episode; thus some humiliation on the playground may have resulted in loss of physical self-confidence, and respect from the other children. An overbearing parent may be the source of the difficulty, or an overbearing teacher. The anxieties of adults may have various more or less obvious causes. Occasionally the individual will be found to have completely forgotten the real cause of his harassed feelings; thus the cause may be so far back in his childhood as to have faded out with other childhood experiences. Under such conditions it is sometimes possible to guess the nature of the difficulty; sometimes the true cause is so far removed from the observable effects that only great care and constant research into the individual's past history will bring it to light.

But every effort should be made (and with the utmost tact) to get at the source of the trouble. Often truly marvelous results (involving mental, emotional, and even physical rehabilitation) may be obtained with adequate understanding and proper dealing with the underlying influences.

Sometimes an individual will be found who shows a mood of chronic irritability or anger. He feels, perhaps, that he has been treated unfairly by a stepfather, by a teacher, or by the community at large, and exhibits as a usual emotional tone a chronic grouch and a desire to "get even" for his difficulties, which may be either real or fancied. Again, the source of the difficulty is to be looked for. Jealousy may operate in somewhat similar fashion.

Emotional Conflicts. When there are emotional difficulties there are usually, however, also emotional conflicts; and the conflict is the important element in the situation. The conflict arises ordinarily because some strong emotion is blocked off from satisfaction by shame, fear, or some similar factor. Thus, a child or adolescent may (the practice is, as will be pointed out later, very much more common than is usually supposed) masturbate and may be terribly frightened, ashamed, and worried about the practice as a result of some of the older type of sex literature which exceedingly exaggerated the possible effects of such actions. (A parent, or even a family physician, may similarly overreact to the situation and do much more harm than the practice itself could possibly do.) The child then comes to think about sex much more than is healthful, the sex feelings are exaggerated, and there is a continual conflict between the desire of these feelings for satisfaction and the individual's fear and shame when he yields to these desires. Very tactful, common-sense, sympathetic inquiry should ultimately lead to the revelation of this difficulty; an inculcation of a more rational attitude in child and parents will usually solve the entire problem.[1]

[1] Often the child is brought to the examiner because he has had a sudden outburst of stealing, lying, or other delinquencies. These out-

The investigator should thus make every effort to determine any concealed emotional "complexes" which may be operating. The examiner should realize that the individual being examined will usually shy away from any attempt to discuss the source of such a conflict. And it should be recognized that, in many instances, this tendency is entirely unconscious; often, indeed, the individual has managed to suppress the unpleasant topic so thoroughly that he himself cannot get at it. The suppressed emotion, then, acts in a way like a concealed infection which occasionally breaks out —sometimes in ways quite mysterious to the patient—but for the most part operates subtly and insidiously to poison the whole mental and emotional life without making its presence known in any obvious or specific way. It is highly desirable that such sources of mental difficulty should be got at. It should, however, be realized that the process is highly painful to the individual and that a blundering investigator often does more harm than good. The matter of methods will be returned to in a later discussion.[1]

It should be realized that most of these difficulties of an emotional nature begin in childhood. It should also be understood that they are the most serious difficulties of all. Intellectual troubles are likely to be secondary to such emotional problems. A school official can render no higher service to a child or adolescent than to clear up such difficulties; a school cannot sin against a child more terribly than in causing such difficulties; it should be criminal negligence for a

bursts in children who have no history of childhood delinquencies are very frequently the result of such a conflict which seems to the child intolerable; the child's emotions "run amuck."

[1] Many writers in this general field leave the student with the impression that all conflicts are due to the suppression of sex desires or experiences of some sort. Such a conclusion is hardly justifiable. It is true that sex desires are exceedingly likely to be suppressed, because of the rather general taboo upon the discussion of such matters. But other emotions and types of experience may give rise to conflicts with equal ease. Remorse or fear that one is ashamed to admit—being ashamed of one's home or family or profession, feeling chronically unequal to meeting the demands of life, may all operate in just the same way as a conflict in the more narrow field of sex.

school to neglect such matters. Every school official—every schoolteacher—should have some understanding of this subject.

To summarize then: Study of the present condition should include (1) study of the physical condition, with due regard to both general health and special defects. There should also be (2) consideration of the general appearance and behavior. There should be (3) study of the individual's intellectual status. Finally, and most important of all, there must be (4) the most tactful, skillful, and wise consideration of any emotional problems.

As illustrative of studies of an individual's present condition the writers are presenting below brief summaries regarding the present condition of the two cases whose histories were given at the close of the preceding chapter. These are much condensed, but should make somewhat more clear and concrete the points discussed above.

CASE HISTORY OF A DELINQUENT GIRL (*Continued*)

IV. Present Condition.

A. Physical Condition.
General Health—Patient is vigorous and robust; has high color, and seems overflowing with vitality. Positive Wassermann.
Special Defects—None.

B. Appearance and Behavior—Is restless; wiggles about on chair. Is dressed in "loud" clothes, and walks with something of a swagger. Winks intimately at the examiner, when asked to explain the cause of her arrest. Uses considerable profanity and some obscenity in explaining matters.

C. Intellectual Condition.
General Level—Earned a mental age of 14-3 on the Stanford Binet, with an I.Q. of 89. Is well within the "normal" group as far as intelligence is concerned. Mental age may be even higher as coöperation was not always of the best.
Special Functional Disorders—Patient appeared somewhat flighty in her conversation; didn't stick to one question very long. Attention was fair, but shifted rapidly and fre-

quently. Memory normal. Rather rapid flow of ideas, but nothing abnormal. Intake normal.

D. Emotional Condition.

General Tone—Rather under-emotional than otherwise, with an emotional blunting.

Indifferent about her delinquencies; has an almost fatalistic attitude about her diseased condition.

Special Emotional Trends—A bit angry at her detention in a school for the "feebs" (a not unnatural reaction) but nothing abnormal.

Emotional Conflicts—None that could be observed. Patient appeared to be too open and direct to admit of suppressions of any kind.

Case History of a Man with Manic-Depressive Insanity (*Continued*)

IV. Present Condition.

A. Physical Condition.

General Health—Has yellow skin, cold hands; extremely constipated. Considerably underweight. Has bad breath and seems poorly nourished.

Special Defects—None.

B. Appearance and Behavior—Underactive.

Sits quietly, staring at the floor; says nothing unless asked a direct question, and then answers very slowly and as if answering were a great effort. Sighs occasionally, and occasionally wrings hands. Facial expression downcast and worried; facial muscles very relaxed. Clothes hang loosely, and have evidently received no care recently.

C. Intellectual Condition.

General level impossible to determine because of the depression and emotional preoccupation. Mental age received was only 10-2, but the record was very erratic, some very easy tests being failed and an occasional very difficult test passed. In view of this last fact (and especially of course because of the school record and business success) it seemed reasonable to suppose that the patient was not actually below average ability, that the poor showing was due to the emotional condition.

Special Functional Disorders—Judgment is disturbed as shown by vague delusions concerning his sinfulness—says that he has been unkind and cruel to his wife (although the history indicates nothing of the sort), that he has been irreligious, and so on. Overconcentration on depressed thoughts from which he does not seem able to escape; attention very difficult to attract—many questions remain altogether unanswered because they are apparently never heard. Memory

apparently normal whenever the disturbed attention permits an answer. Association extremely slow; thirty seconds often elapse after a simple question before the monosyllabic answer is given; the answers when they do come are entirely relevant, however.

D. Emotional Condition.

General Tone—Much emotion of a depressed nature, as evidenced by posture, facial expression, and patient's own statements regarding his feelings.

Special Emotional Trends—Patient is disturbed by remorse for sins which do not appear to have existed (are very likely simply rationalizations—are unconsciously hypothecated by the man to make reasonable to himself his depressed feelings). Is so dominated by these feelings that he can think of nothing else.

Emotional Conflicts—Occasionally some suggestions of an actual background emotional problem, but nothing definite can be determined regarding the matter.

CHAPTER IV

THE TECHNIQUE OF CASE STUDY

The two previous chapters have dealt with the knowledge about an individual's past and the observations with regard to his present condition which are necessary for a total appraisal of the case. It might seem that, with these points in mind, one must be ready for the actual study of cases. Such an impression is not merely untrue, it is exceedingly unfortunate—as has already been implied. The social worker who curtly inquires—pencil in hand—"Any insanity, epilepsy, or feeble-mindedness in your family?" very often so antagonizes the informant that she misses the important facts; and even the most tactful of investigators cannot later extract the important personal information desired. It is all in the way one goes about it! It may almost be said that knowledge as to what facts are desired is usually found even in beginners; but only the experts have the skill requisite to obtain this information. Certain elements in this skill can, perhaps, be acquired only through practice; but other elements may surely be learned. The beginner can, at least, be warned to avoid certain conspicuous errors. The beginner can also be given a few hints about the kind of record he should keep, and can be made to feel that facts in themselves are of no particular importance but that there is a final aim to the business of fact-collecting—that there should result an understanding of the case expressed in the form of a diagnosis. The present chapter deals with such matters of procedure, which may seem unimportant to the beginner, but which very decidedly condition both the obtaining of correct information and the usefulness of it.

The Interview

Usually the most important source of information is the interview with the individual concerned; sometimes this is the only source. The interview may take place under a variety of circumstances, each having its advantages and drawbacks. If the individual comes to the investigator's office an interview in strict privacy should be possible; outside distractions should be avoidable, and the examiner should have the situation well under control. This should always be the case with the school official. There is the further advantage that the total surroundings in the office make up a "standard situation." One can then compare the behavior of successive cases, circumstances and surroundings heing constant; much more satisfactory comparisons are thus possible.

However, not all such work can be done in the interviewer's office. This is especially true in social work. Many times the case must be met in the home—very likely a home overrun with children, perhaps a home in a crowded district where other adults are also about. Little or no privacy is possible, and there are constant distractions. Naturally, confidences are hard to obtain under these circumstances. One cannot "psycho-analyze." Any real note-taking is usually out of the question. The chief redeeming feature of the situation is that the "patient" is seen in his natural environment, rather than in the artificial and perhaps embarrassing environment of the office. It need hardly be added that the individual's home environment is a thing that should always be studied as an aid in understanding the patient, even though it may not be an ideal place for an interview.

The individual may also be seen in a hospital or jail or while waiting to appear in court. Under such circumstances the subject is likely to be under emotional stress, as well as physical constraint, and a still different problem is presented. In any case, the situation is complicated by the legal aspects of the matter.

It is obvious that the approach and progress of the interview must be different for each one of these different situations. Certain general principles, however, do always apply:

(1) The individual must be met in a friendly spirit, without any condescension and without any traces of boredom or impatience, and he must be made to feel that he is being treated absolutely fairly—and sympathetically. The interviewer should always be genuinely interested, if possible; and he can develop, for use at times when he is ill or tired, a manner and appearance of interest that is difficult to distinguish from the "real thing." There is no excuse for abruptness or carelessness with the person interviewed; anything of the sort is a mere showing of bad manners.

Perhaps the school official is most often guilty of abruptness and lack of a sympathetic attitude. For purposes of discipline it is, of course, often necessary to be stern, and refuse to consider excuses. But that is another matter. In study of a problem case there is hardly any attitude worse. The child gets the feeling that "anything he says may be used against him," and that his feelings (the source of the trouble) will not be considered. The confidence of the individual simply must be won. This does not preclude an even-handed justice in dealing with any case—in fact, that is required. It does demand a full, sympathetic understanding of the individual's point of view and an effort to get at the origins of his difficulties.

(2) It must be remembered that "emotional thinking" does not proceed according to the rules of logic; and that in many cases a difficulty has developed from circumstances which seem totally irrelevant. An individual's behavior may seem absolutely without reason—absolutely bizarre—and yet may, once the emotional background is revealed, be readily appreciated. An emotion may express itself symbolically. It may predicate imaginary circumstances with reference to which the individual acts. Emotional pressure often works itself off not at all with reference to the cause of the pressure, but simply where re-

sistance is weakest. The emotional life tends to go on in ways which are in a sense unintelligible to the intellect. For understanding abnormal individuals, not only intelligence but imagination, and some little emotional experience, are necessary.

A boy may set a barn on fire because he has suddenly found out that he is an adopted child. A young woman may have a paralysis of the left arm because she wishes the attentions of a young man (she had written letters, as if from a man to herself, using her left hand to disguise her writing). Another boy may steal because he has been masturbating. A child may vomit whenever he is scolded at school. Another may have an "epileptic" fit every day at three o'clock. All most extraordinary happenings—but very understandable (as will be seen later) if all the circumstances are known. The point is, that the investigator should be willing to inquire into all these apparently irrelevant circumstances.

(3) The interview must not be artificial; it must proceed as easily and naturally as a pleasant social call. It should go without saying that, after the first greetings, the transition to the real business of the interview should be easy and natural. The interviewer should have no set procedure by which he tries to control and develop the interview (though he may later record the facts gained in systematic fashion), but should begin with whatever he thinks will be of greatest interest to the person interviewed. As suggested in a previous chapter, the "present difficulty" is usually the focus of interest; the investigation should, thus, ordinarily begin here. The interview should then go on naturally, like a friendly talk, the individual bringing up this or that topic as it seems to him relevant, with relatively little prompting from the interviewer. This does not mean that the case should "run" the interview, however; it means that he should be "run," but without his knowing it. This is especially important with the garrulous person who, if not controlled, will talk on interminably without saying anything of importance, but who will resent the slightest evident attempt to curtail his remarks.

Usually, it is best not to take notes in the presence of the person interviewed. If the interview takes place in the home, or at the person's place of employment, note-taking may be positively ill-mannered. In his own office the interviewer may jot down an occasional brief note, especially if the interview be a very long one. There is one important exception to the above suggestions: if any names or addresses are to be taken down, these should be written out at once. By so doing, it is often possible to save oneself useless trips to half-remembered addresses that don't exist.

(4) Finally, it must be remembered that it frequently takes more than one interview to get all the necessary details of a case; therefore, one interview should always be finished so that another may be begun easily and without awkwardness. A crude pushing for information during the first interview may so antagonize as to make future interviews impossible.

Other Sources of Information

There can never be a question as to whether there should be other sources of information than the individual's own story; always auxiliary information should be obtained, if possible. The sources vary more or less according to the nature of the case and the problem. However, in general it may be said that one hopes to obtain information always from the teacher if the case is a child, and from at least one member of the immediate family; information from the neighbors and from companions is also desirable. If the case is an offender or dependent there should be information from the parole officer, the prison authorities, the truant officer, the police, or from social agencies. Interviews with such individuals usually take place at the home of the informant, at his place of business, or in some even more public place; it is field work, not office work. Many such conversations may take place over the telephone. In all instances the important thing is that the investigator should know what he wants and should be able to get the desired information without disturbing the informant any more

than is necessary—particularly if this informant be the busy employer, physician, or officer of the law. The chief value of these talks is to substantiate, modify, or repudiate the patient's own story. The investigator should have thoroughly digested the individual's own account, and should have sorted out the important facts for verification, before he attempts interviews with outsiders. Otherwise, he is likely to waste time and, after the informant has been seen, discover vital facts he has forgotten to ask about. This does not mean that the investigator should have his mind closed to everything but the particular information he is after; he should be free to follow any worth-while leads that appear. But it is only courtesy to those interviewed that the number of questions asked (and time taken) should be reduced as much as possible.[1]

A word remains to be said about the use of records belonging to the police, jails, reform schools, hospitals, social agencies.

[1] Two or three practical hints to social workers regarding field work are perhaps worth mentioning. Such apparently non-essential matters as the investigator's personal appearance and clothes are really of importance. In interviewing officials, doctors, other professional men, employers or social agencies, the social worker should be dressed "professionally," that is in dark suit, simple waist, sensible shoes, etc. A business-like appearance is a great asset in getting the attention of such people. In visiting the home of a patient it is sometimes best *not* to appear professional. If a woman's son breaks his leg, and is sent to a general hospital, everyone is sorry for her and she rather likes to have her neighbors know that a hospital social worker has been to see her. But if her son is delinquent, or has become insane, she usually doesn't care to have the neighborhood reminded of the fact by the intrusion of a person whose clothing positively shrieks "social worker." If she can tell her neighbors that the caller was a "friend" she will feel much better satisfied—and will be much more coöperative.

The social worker, or other investigator, is sometimes obliged to get information from somewhat unsavory sources—from saloons (though this may be a thing of the past), from poolrooms, or even from a disreputable house. It is best, under such circumstances, to emulate the Catholic sisters and take some one else along. In any case, one should remember that the police are available, and are usually willing to go with an investigator while she makes her inquiries. There is seldom any real danger in such visits anyway; but the presence of a policeman will insure a respectful answer and will prevent unwelcome attentions from idlers. In fact, whenever one is in a "bad" district—as one is rather likely to be occasionally—it is well to know where the police are stationed; and no woman should hesitate to appeal to the passing policeman even if only for protection from small annoyances.

These records are usually open to the accredited investigator, and often throw much light upon an individual's personal history. Indeed, the first thing for a social worker to do in investigating a case is to telephone the "Confidential Exchange," if there is one, and find out if the case has ever come in contact with any other agency. One should promptly avail oneself of the information in such records, if possible, and should use this record as a starting point for the present investigation. It should be understood that all such records are of a confidential nature, and they should be treated as such.

One further word of caution is necessary. A suspicious manner toward informants should always be avoided; but every source of information must be more or less under suspicion! The investigator must be kindly, but shrewd. The chief questions in this connection should always be, "What is this informant's relation to the person concerning whom he is giving information? Have the facts he has given any important relation to his own affairs?"

It should be constantly kept in mind that information is very often highly unreliable, prejudiced, or even maliciously untruthful. The writers knew of an attempt on the part of a supposedly respectable husband to have his wife committed as insane in order to get rid of her. In another case it became reasonably certain that a stepmother was bullying her stepchildren into delinquency so as to get them sent away to reform school. The informant's relation to the case should always be clear when weighing his evidence,—and, naturally, the extent of his acquaintance with the case.[1]

The Record

The writers are tempted to say that the most important thing about a record is that there should not be too much of it!

[1] When an item of information is important and possibly subject to question it is well to indicate in the final record the source of that information. And in general it is a good practice to list at the beginning of a case report the sources of information on which that report is based. The practice has, it will be noted, been followed throughout this volume. The reader should note also the suggestions in Appendix A.

They have had much experience with people who seemed to think that merit in a record was chiefly a matter of length. It is surely obvious that all facts which have a bearing upon the diagnosis and treatment should be recorded. And it may be granted at once that some facts which do not at first seem important may later become so. But it should also be obvious that one very soon comes to the point, in the garnering of facts possibly relevant, where the possibility that these facts will be important is negligible compared with the need of work elsewhere. One must take account of the total economy of the situation. One must certainly not include so many mere facts that the important outlines of the situation are hidden. There is a further very important consideration that is frequently overlooked. Real steps forward in study of mental and social problems can come only through research. There is a striking lack of systematic research in this field. From weary experiences in such work the writers have come to believe that the appalling mass of unorganized, inconsequential data which make up the records of the average school psychologist, social agency, clinic, or hospital is largely responsible for hampering or preventing research in these fields. The significant facts are, usually, to be found in such records. But they are scattered piecemeal through a mass of largely irrelevant matter which wearies eye and brain unspeakably in the effort to obtain even a modicum of real information.

Thus psychiatric case records often consist very largely of detailed stenographic reports on matters which might well be summarized in a few sentences. For instance, the following information is furnished regarding a young woman sent to a clinic by a court for study because of her repeated shoplifting; she can touch her nose with her finger with her eyes closed; she knows the name of the first president, and the longest river in the United States; she knows her own name, the kind of place she is in, and why, and she knows the date; she can handle simple questions in arithmetic. In all this inquiry she shows nothing abnormal. Every detail of the inquiry is

included, but without any summary at the close of this part of the study, so that one has to read through all this detail in orqer to reach this conclusion. It may be desirable to include on separate sheets such detail of the examination of the patient,[1] but it should not appear as an integral part of the final case record. In another instance, there is a long and elaborate family and individual history, with all possible details, an equally detailed and uninteresting mental examination, with still almost nothing of psychiatric significance—then suddenly the statement that the laboratory findings on blood and spinal fluid are unmistakably positive and that the patient is undoubtedly suffering from general paresis. Again these first details have value; it is of scientific interest to know that this case has a healthy family, was normal up until recently when loss of memory has been noted, and even now shows nothing in the way of definite abnormality in the mental examination. But the final record nowhere brings out these general implications; the record is essentially a list of all the various things done and questions asked in any routine examination, with the remark after each one that nothing abnormal appears.

The major difficulty, of course, is that most records are not properly organized, in some simple, clear, systematic fashion which will permit the reader to find his way about in the report. In fact, some simple general outline is almost as essential as some sort of accepted technical vocabulary, if the records are to be of the greatest general usefulness.[2] The

[1] It is of course desirable so to do (where filing space is adequate), and it is common practice; each case has a folder in which appears first the systematic report and then all the examination blanks, notes on visits to informants, and day-to-day jottings about the case, on which the final report is based. But the record-writing must then be constantly watched or the record will degenerate into the barest perfunctory skeleton outline, totally inadequate for any understanding of the case. The reader must then turn to the "cold" notes and first jottings on the case (often almost illegible) and try, somehow, to piece the story together from all these tag-ends of data. . . . A coherent, systematic final record-report is, the writers feel, essential for good case study work.

[2] When an outline is used it is frequently too long and involved. An unwieldy outline is an abomination; it burdens instead of helps the

outline discussed in the two previous chapters, and brought together in the Appendix, is suggested as useful. The particular form employed does not matter especially. The important consideration is that the outline should be useful and usable —so simple, straightforward, and brief that any reader will quickly understand it, and be guided and helped in his use of the report, and yet sufficiently comprehensive to assist the investigator in the organization of all material which may possibly be obtained with regard to a case.

The record should, then, be clearly coherent and reasonably brief. However, clearness and compactness must not be obtained at the sacrifice of definiteness and objectivity! The report must be specific, not deal in generalities. And it must give, so far as possible, facts, not merely opinions of the investigator or an informant—must be objective. The two reports following will illustrate these distinctions. The reports are of visits made by two investigators to the home of a girl who is a mild social problem. The notes are not, it will be observed, as yet organized—are simply jottings made immediately after a visit. They will illustrate also the nature of some of the "raw material" from which the final record is eventually composed.

Mary M. comes from a large middle class family living in a respectable but shabby neighborhood. Mary's home is somewhat better than most of the houses that surround it. There seems to be evidence that her mother tries to make a home that will keep her children contented and happy. Mary herself is a bright lovable girl, popular with others of her own age. She has done good work in school and her teachers seem to have been fond of her, although she was never one of their best pupils. Recently she has been somewhat wayward and hard to manage. Her attitude toward her family has changed, probably because of the family's inability to meet her growing financial demands. Mary's mother complains of a general lack of coöperation. The father does not seem able to make enough money to support his family and the mother and Mary appear resentful of this condition. Mary has been working in a store to get

investigator and tends to confuse the reader. An outline must be an aid and not a fetish.

more money. The general atmosphere of the home seems to have been very good until recently when Mary has become something of a problem to her parents.

Mary M. lives with her parents, a grandmother, and four younger children in a six-room frame house. The rooms contain very little furniture, but there is a piano in the living room, electricity throughout the house, and a modern gas range in the kitchen; the whole house is clean and neat. The neighborhood is made up of small houses, most of them badly in need of painting. Mary's house is in better condition than most of the others seem to be. There are a few tenements farther down on the street, which is overrun with poorly dressed and noisy children. Mary has finished the ninth grade in school at 14 years; the three teachers interviewed all say she is bright and willing to work. She has many friends of her own age, belongs to a club which sometimes meets at her house. Mary's mother says she constantly goes out when told to stay in the house, that she refuses to help with the housework, that she demands money in larger amounts than they can afford to provide, and that she has recently used profane language when scolded for her changed attitude toward her home. Mary's father is a bookkeeper who makes $32 a week. The mother says this is inadequate for their large family. Mary has recently been working in Green's store as a clerk at $10 a week.

The first investigation speaks of a "large" family, the second gives the number of persons, mentions that the four other children are younger than Mary, mentions the grandmother. The first report simply indicates the mother's good intentions regarding the home; the second gives the size, and mentions various specific features such as the piano, showing an effort to make the home comfortable and enjoyable. The second report tells how far Mary went in school and includes a statement of the agreement of three teachers as to Mary's behavior and work while in school, gives the father's occupation and wage, also Mary's wage and the place where she works. The first report gives none of these things. Not all of these details are necessary, perhaps. It might be better if the second investigator had given more of her impressions regarding the home, had stated that the mother "tries to make a home that

will keep her children contented and happy" instead of leaving it to the piano and general condition of the house to evidence this attitude. But the general superiority of the second report is obvious.

The investigator should make it a practice, then, to put down things in as specific, definite, and objective a form as possible. Where an opinion or impression of some one interviewed is included in the report, there should be a statement to that effect. A little conscientious practice in thus observing closely and keenly and recording accurately will bring marked improvement—and will bring also clearer and more accurate thinking about the cases dealt with.

All of this does not mean that the report should be crammed with a mass of undigested details; a report can be specific and objective and still be brief and clear. Nor does it mean a report from which all human sympathy and understanding have been eliminated. It means simply a report which is as intelligent and accurate, and gives the reader as clear and true an understanding of the person studied, as possible.

The Summary and Conclusions

Many of the beginner's difficulties as to what facts should be investigated and what recorded would be readily solved if he or she would only keep in mind that a case study is not simply an indiscriminate exercise of curiosity with regard to the personal affairs of the individual concerned, but is an effort to understand that individual with reference to the problem which has brought about the investigation. The investigator should be able, after the investigation is finished, to arrive at some conclusion with regard to the causes of the individual's difficulty and to make some suggestions as to what may be done to solve these problems. These conclusions and recommendations may perhaps be of only a tentative nature. But it is obligatory upon the investigator to interpret the data he has gathered to the best of his ability. If the person having first-hand contact with the data, and fresh from the study of the

situation, cannot arrive at a conclusion, probably no one else can. Always, then, after the write-up of the case there should be a final summary and judgment with regard to it.[1]

The summary should be brief. It should use a consistent vocabulary and should refer back to specific points in the report. It may be well to make a "differential diagnosis"—that is, a brief statement of the three or four facts supporting the conclusion arrived at, followed by a statement of any other likely conclusions with reasons why these were *not* adopted.

It is common in such reports to speak of the conclusions as the "diagnosis" and to refer to the facts leading to this conclusion as the "symptoms." These terms are, of course, used in a very broad way. Thus outbursts of temper, fainting spells, fear of the dark, seclusiveness, depression, failure to hold jobs, failure in school, stealing, bad companions, sexual immorality, a drunken father, insane parent, are all symptoms in this larger meaning of the word. And a diagnosis may run all the way from arteriosclerosis or congenital syphilis to poverty, alcoholism, or family dissension.

In order to illustrate methods of summary, a brief statement of summary and conclusions, regarding the two cases already used as examples, is given below:

CASE HISTORY OF A DELINQUENT GIRL (*Concluded*)

V. Summary and Conclusion.

A. Summary—Father alcoholic and criminal, older brothers delinquent but apparently normal in intelligence, mother immoral and syphilitic, two younger children feeble-minded (syphilitic?). Extremely bad home environment. Patient immoral since early childhood, stayed out nights, truant, generally tough. School work about average. Finished one

[1] This does *not*, of course, mean that a clinical psychologist or social worker should venture a medical diagnosis with regard to an individual, or that an investigator should in any way trespass into fields where he is not qualified to judge. It does mean that the investigator should to the best of his ability formulate the problem presented to him, and come to as definite a conclusion as possible with regard to such matters as are within his province. If he is inexperienced he should say so, and should have the case reviewed by an expert. But he should do the best thinking he can in the matter.

year high school. Has been prostitute for past two years. Now syphilitic. Shows slight emotional blunting and some superficial excitability. I.Q. 89.

B. Conclusion—A fairly normal girl, a victim of very bad home conditions. Not feeble-minded, for did good school work even in second year of high school and has I.Q. of 89. Not psychopathic for no evidence of sufficient emotional instability, no emotional episodes or other peculiarities.

CASE HISTORY OF A MAN WITH MANIC-DEPRESSIVE INSANITY (*Concluded*)

V. Summary and Conclusion.

A. Summary—Suicides in family. Patient has had periods of depression, one attack of excitement, two previous hospital admissions. Recent attempt at suicide. At present much depressed, shows insomnia, loss of appetite, loss of weight, constipation, seclusiveness, emotional preoccupation concerning sinfulness, vague delusions, slow association.

B. Conclusion—Manic-depressive insanity, depressed phase.

COMMON SENSE IN CASE STUDY

The task of investigating peculiar personalities requires a great deal of that ill-defined group of abilities called "common sense." The present section is intended to comment upon certain offenses against "common sense" as that quality should function in the investigator's work.

It should be obvious in the first place that no one who starts out to make a study of human beings should be lacking in interest in and sympathy for people. Investigators are sometimes found who have reduced their process of making investigations to an almost wholly mechanical level. Their work is vitiated by such an attitude; they inspire neither trust nor respect in those they interview. However, the investigator must not be sentimental. Sentiment has little or no place in the investigator's equipment. Appeal to sentiment is the one great "graft" against which the worker must constantly be on guard. It might almost be said that those who deserve sympathy are the ones who do not ask for it and that those who most deserve it actually resent it.

Above all things, prudishness is unfortunate. If one is

prudish, one often fails absolutely to get at the key facts to a situation. The writers venture the categorical statement that no one who is unwilling to talk freely about sex matters should undertake any such work. Data regarding sex difficulties should be treated as so many facts along with other facts about schooling and work, with only, perhaps, an added sympathy from the realization that sex difficulties are peculiarly troublesome—and that mere expression of them and contact with a kindly, common-sense attitude often gives the required relief to the individual. The investigator should remember also that sex manifestations are not at all uncommon in children, and that the attitude on sex matters varies markedly from one social class or from one nationality to another. The school official should keep in mind that sex problems usually begin during childhood, and that probably the greatest single need, for coping with nervous difficulties in children, is the sensible-minded adult with whom the child can talk about his difficulties with complete frankness—and who will engender in the child not shame and anxiety and sentiment, but a more or less impersonal understanding, confidence—and diversion of attention to other interests.

Another frequent sin against common sense appears in the complete blindness of many investigators to the fact that there are many standards in cleanliness, manners, dress, intelligence besides their own. One is very likely to judge too severely a man from a slum district who has his underclothes sewed on for the winter, who lives with a woman who is not his wife, and who chews a toothpick during the interview. He may be reasonably intelligent and willing enough to conform to prevailing standards of cleanliness and morality—only his standards are not those of the investigator. One must not expect too much in the way of readiness in conversation or quickness in the appreciation of things from unschooled laborers, or delinquent girls of the same social class. As is now being realized, an exceedingly unfortunate overestimate of the prevalence of feeble-mindedness among delinquents was

one result of the failure to appreciate such differences between the investigator and the delinquent. Particularly should the difficulty in judging either the mental or the moral standards of the delinquent be realized.

Finally, the investigator will save himself from falling into many of the errors above referred to if he preserves a sense of humor. Things unspeakably ridiculous frequently appear in the study of mental abnormality. It must not be inferred that an investigator should laugh *at* a patient. But a sense of humor will often bring home to one, vividly, incongruities in many situations which would not rightly be appreciated otherwise.

To summarize, briefly: The chapter deals with certain matters of general method in case study. (1) The interviews with the individual concerned should be under as favorable circumstances as possible, and should be friendly, appreciative of the peculiarities of "emotional thinking," natural in development, and so terminated as to facilitate further contacts. (2) There should be a businesslike and shrewd use of other sources of information than the interview with the individual being studied. (3) The final record should be clearly organized and should contain only relevant information; and it should be as specific, definite, and objective as possible. (4) There should be a compact summary at the close of the record and a statement of the investigator's conclusions. (5) A common-sense matter-of-fact attitude is essential; there must be no sentimentality, no prudery or avoidance when sex matters appear—and the investigator must have a sense of humor.

References—Part I

References for further reading are listed below. These references have been grouped according to general fields of interest. Special attention is called to the books and articles including case studies presented in the last group; the reader should be sure to consult at least some of these studies. In addition there is, in the Appendix

of the book, an alphabetical list of all books to which reference is made. This list is annotated, so that each reader may select more accurately those further readings which will be of most interest and benefit to him.

1. Case Study Methods in Social Work.
   Richmond, M. E., *Social Diagnosis,* Chaps. 1-16, 18, 20-27.
   ——— *What Is Social Case Work?* Chaps. 2, 3, 6.
   Sheffield, A. E., *Social Case History,* Chaps. 1-6.
   Bogardus, E. S., *Methods of Training Social Workers,* Sections 1-18.
   Chapin, F. S., *Field Work and Social Research,* Chap. 4.

2. Case Study Methods in Psychiatry.
   Southard, E. E., and Jarrett, M. C., *The Kingdom of Evils,* Book IV, Chaps. 1, 2, 7.
   Yerkes, R. M., and LaRue, D. W., *An Outline for the Study of Self.*
   White, W. A., *Outlines of Psychiatry,* Chaps. 6, 18, 19, 20.
   Rosanoff, A. J., *Manual of Psychiatry,* Part I, Chaps. 2-6.
   Goddard, H. H., *Feeblemindedness: Its Causes and Consequences,* Chap. 2.
   Tredgold, A. F., *Mental Deficiency,* Chaps. 17, 18, 19.

3. Case Study Methods in Personnel Management.
   Laird, D. A., *The Psychology of Selecting Men,* Chaps. 5-8, 10, 13.
   Link, H. C., *Employment Psychology,* Chaps. 18-19.
   Weakley, F. E., *Applied Personnel Procedures,* Chaps. 3, 4, 12.
   Scott, W. D., and Clothier, R. C., *Personnel Management,* Chaps. 6, 7, 11-16, 18, 20, 23.
   Fennell, R. T., "Art of Interviewing," *Industrial Management,* Vol. 60, pp. 310-11, 1920.
   Masterson, J. F., "Art of Interviewing," *Industrial Management,* Vol. 61, pp. 159-165, 292-298, 1921.

4. Case Study Methods in the Schools.
   Parsons, F., *Choosing a Vocation,* Chaps. 3-5.
   Bloomfield, M., *Youth, School and Vocation,* pp. 177-261.
   Terman, L. M., *Intelligence of School Children,* Chap. 10.
   Meyer, "The Program of Mental and Moral Health in the Schools, in *Suggestions of Modern Science Concerning Education,* by Jennings, Watson, Meyer, Thomas.

GROSZMAN, M. P. E., *The Exceptional Child,* Part II, Chaps. 12-16.

BALDWIN, B. T., and STECHER, L. I., *The Psychology of the Pre-School Child.* Appendix VII.

5. Case Study Methods in the Courts.

HEALY, W., *The Individual Delinquent,* Chaps. 5-7.

BRECKENRIDGE and ABBOTT, *The Delinquent Child and the Home,* Appendices 4-6.

HOAG, E. B., and WILLIAMS, E. H., *Crime, Abnormal Minds, and the Law.* Part III.

BURT, C., *The Young Delinquent,* Chap. 1.

6. Examples of Case Studies in Various Fields.

Child Guidance Clinic, *Three Problem Children.* (Educational.)

VAN WATERS, M., *Youth in Conflict,* Chap. 1 (Juvenile Court).

DRUCKER, S., and HEXTER, M. B., *Children Astray.* (Educational and Social.)

KRAEPELIN, E., *Lectures on Clinical Psychiatry.* (Psychiatric.)

GODDARD, H. H., *Feeblemindedness: Its Causes and Consequences,* Chap. 3. (Feeble-minded.)

HEALY, W., *The Individual Delinquent.* (Juvenile Court Cases.)

SOUTHARD, E. E., and JARRETT, M. C., *The Kingdom of Evils,* Books I, II, III. (Psychiatric.)

LATTIMORE, E. L., *Some Illustrative Cases.* (All Types.)

PARSONS, F., *Choosing a Vocation,* Chap. 15. (Vocational.)

WILLIAMS, G., *The Problem of Restoration: A Clinical Study.* (Educational.)

TERMAN, L. M., *Intelligence of School Children,* Chap. 11. (Educational.)

HEALY, W., *Mental Conflict and Misconduct.* (Court cases.)

SOUTHARD, E. E., *Shell Shock and Neuropsychiatry.* (Psychiatric.)

DERSHIMER, F. W., "Practical Mental Hygiene in Industry," *Journal of Industrial Hygiene,* Vol. 5, pp. 1-7, May, 1923.

RAPHAEL, T.; JACOBY, A. L.; HARRYMAN, W. W., and RAPHAEL, M. M., "Socio-Psychiatric Delinquency Studies from the Recorder's Court, Detroit," *Mental Hygiene,* Vol. 8, pp. 453-65, April, 1924. (Court.)

BLANCHARD, P., and PAYNTER, R. H., "The Problem Child," *Mental Hygiene,* Vol. 8, pp. 26-54, January, 1924. (Educational and Court.)

LAIRD, D. A., "Case Studies in the Mental Problems of Later Adolescence with Special Reference to the Mental Hygiene of

the College Student," *Mental Hygiene,* Vol. 7, pp. 715-33. (Educational.)

Myerson, A., *The Nervous Housewife,* Chaps. 10-11. (Social.)

Sayles, M. B., *The Problem Child and the School.* (Educational.)

Judge Baker Foundation, *Case Studies.* (Court.)

Scott, A., "Neuropathic Work in Industry," *Mental Hygiene,* Vol. 7, pp. 521-537. (Industrial.)

Exercises in Application

1. Write out case studies of four or five unusual people you have known. See if you can make the cases both accurate and interesting. Can you come to any conclusion as to the nature of the difficulty?
2. What facts from all those suggested in the preceding chapters would you want to know about the pupils in your school if you were the vocational counsellor? Are there any facts not included in the above outline that you would want to find out? If so, what are they?
3. If possible, pay a visit to a juvenile court, a state insane hospital, a social agency, a school for the feeble-minded, a special class in the public schools. Write a brief report on the cases you observe.
4. If possible examine the records of some clinic, state hospital or social agency, also find out what records are kept by the public schools. Do you find facts that are not included in the outline of this book? Are there any facts not covered in these records which you think should be covered? Are the records written and summarized in such a fashion that they may be used easily? If not, what criticisms have you to offer?
5. Rewrite two of the case studies from your readings so as to present them in terms of the outline given in these chapters. Make a separate list of any facts concerning these cases that do not seem to fit into the outline anywhere. Do not omit anything from either case history, but rewrite the facts to fit this different outline.

PART TWO

TYPES OF MENTAL DISEASE AND DISABILITY

CHAPTER V

THE CLASSIFICATION OF MENTAL TYPES AND DISEASES

The text so far has dealt with methods by which a case may be studied. The present section aims to indicate roughly the various conditions and types which may be found in the actual study of cases. The third and last part (it may be added), will discuss general causes, treatment, prevention, and data regarding the prevalence of mental disease and feeble-mindedness, number in institutions, expense and loss involved, and so on.

It should be said at once that diagnosis is often extremely difficult, that different "types" often merge imperceptibly into each other, that many of the disease entities are not well established. Further (as was pointed out in the first chapter), all cases are highly individual; any classifying at all involves a certain violence to the facts. The reader must also be warned against the idea that mental disease is like tuberculosis or typhoid fever, that one either has or else has not. In most instances the comparison should rather be with dyspepsia, constipation, or insomnia; some part of the total organism is not doing its work as it should—and conditions vary by imperceptible degrees from normality. It should also be realized that, in somewhat the same fashion as one's stomach seems to digest better at one time than at another, and one may occasionally have a digestive upset without by any means having an unhealthy stomach, so one may have his emotional and intellectual ups and downs, with an occasional more serious disturbance in one field or another, without being mentally abnormal. The classification into normal and ab-

normal is, in fact, very unfortunate. It implies, in the first place, that there is a hard and fast line between the two conditions, which is about as sensible as a classification of all digestive systems as either diseased or perfect. And, in the second place, the word "abnormal" seems to carry with it a certain stigma of degeneracy or mental depravity, when really such an attitude is usually no more deserved in mental than in physical disease. In fact, the writers would prefer for the most part to speak, not of "abnormal" individuals or states, but rather of conditions of mental disease or deficiency. And they will from here on avoid mention of "insanity" so far as possible (insanity being a legal, not a medical term, and carrying with it unfortunate implications as to legal disability).

No hard and fast lines of demarcation are possible, then, in classifying morbid mental conditions. Some classification is necessary, however; so a first rough grouping of cases as normal, borderland, psychotic, or feeble-minded will be suggested. No one of the four terms is wholly satisfactory. By "normal" is *not* meant a condition of perfect health. The majority of individuals are no more in perfect mental health than they are in perfect physical health; there are few of us who take care of ourselves either physically or mentally well enough to be in perfect condition. But most of us get along somehow, physically—though not by any means living up to our maximum efficiency. So it is both physically and mentally. By "normality" in both instances is meant that wide range of conditions exhibited by those of us who have reasonably good constitutions, and have not abused them *too* excessively.

There are other people who are, constitutionally, not physically strong. They have, perhaps, a digestive system which rebels at the slightest overburdening, and is altogether incapable of standing up under the stress of an ordinary, happy-go-lucky, "pie-à-la-mode" existence. The possessor of such a stomach, if willing to be always careful, gets through life very nearly as well as any one else. But the slightest carelessness brings such a person up short, with an acute digestive upset.

And there are other individuals still who began life with a good enough digestion, but who, by constant excessive abuse, have reduced themselves to a gastronomic invalidism. Just so it is with one's nervous system. Some people start life with a mentality not as vigorous as might be, or a personality unstable and easily unsettled. Some few others have grossly abused their nervous and mental constitutions. In both instances recognition of the disability, and a continued guarding of one's mental health from stress, plus discipline in right habits, will permit a reasonably untroubled existence. But the slightest laxity may result in an altogether disproportionate amount of mental trouble. This group is, then, called by the writers the "borderland" group. It consists of people whose mental health is poor, who are frequently "ailing," but who are not really sick. These people have a lack of resistance, sometimes constitutional and sometimes acquired, which causes them to suffer disproportionately from any stress.

The analogy can be carried further. If one has a weak stomach (or even occasionally, when one has a fairly good digestive system) and abuses it constantly, recklessly, without the slightest regard for the laws of health, one may develop an actual disease. This final diseased condition may be definitely organic. The trouble in the first place, nevertheless, was simply functional weakness plus poor hygiene. So, apparently, a psychosis (that is, a definite change of the personality, which is a condition analogous to organic disorder in the realm of physical disease) may develop from a constitutional weakness when there is a lack of mental hygiene. Or, perhaps, flagrant failure to follow the laws of mental health may bring even a strong person to this condition.

Finally, an organic disease may come about through infection due to carelessness or chance, or through injury or great physical strain; an individual contracts typhoid fever, or venereal disease, may be injured in some accident, or fall, may become broken in health as the result of exposure or shipwreck. And in just such ways a mental disease may be

brought about. There may be a delirium in the course of a fever. Syphilis may attack the central nervous system. Or some great physical strain or exhaustion, or some injury, may bring about mental trouble.

There is still one other type of mental condition that may be considered in similar fashion. Some individuals, as the result of accidents, disease or heredity, are deformed, weak, or defective physically (frequently from birth). There is no active disease process. However, there is something more than a susceptibility to disease, or an inadequate functioning. There is a lack or peculiarity of a static nature, which cannot be remedied, and is a continual handicap. Similarly, an individual may, sometimes as the result of accident, more often as the result of disease, but most frequently as the result of hereditary deficiency, be mentally weak or deformed—or feeble-minded. Such conditions are not progressive, not curable; they are permanent weaknesses.

This second part of the book will take up, in order, these various conditions. First will be considered, (1) normality, then (2) the borderland conditions. Next will come chapters upon (3) the functional and (4) the organic mental diseases, and (5), finally, a discussion of the feeble-minded.

CHAPTER VI

THE "NORMAL" INDIVIDUAL

The first thing concerning normality to be fully realized is—that very, very little is known about it! We know (as will appear shortly), little enough about individuals who are mentally abnormal; but, at least, abnormality has been studied, intensively and extensively. Normal individuals have received almost no such study. So about all that can be said regarding normality is that it is a lack of abnormality.

It is interesting in this connection that it is common practice among psychiatrists, in dealing with "normal" cases, to make a diagnosis as "not psychotic—not feeble-minded." They do not make a diagnosis of "normal."

There is really, of course, somewhat the same difficulty with regard to physical diseases. People who are sick go to a doctor, and he studies their condition; but people who are reasonably well do not come to him and are not studied. Occasionally, however, a normal individual comes under observation. And sometimes such a person shows an extraordinary condition of this or that organ; there may be decidedly slow pulse rate, a complete lack of knee-jerk, or some minor deformity or lack of development. Practically any experienced general practitioner knows of a number of such cases of individuals who are, nevertheless, "normal," in any reasonable definition of that term—that is, they are neither diseased nor deformed. In fact, the writers believe there can be no question but that the extent of the variations in function and development, which are still not to be considered pathological, is not appreciated by most physicians. However, routine physical examinations, in schools, in connection with insurance or employment, and more recently in connection with the draft, have given data with regard to the range of variations in physical condition among normal people. About mental conditions no such body of knowledge exists, partly because people are much more reticent about their mental history than they are about

the story of their physical ills and complaints, and partly because practical reasons have not dictated such systematic inquiry about mental health.

The result is that in discussing mental normality the writers are venturing into a largely unknown subject—a subject really much more fascinating than abnormality, presenting incomparably greater variety and richness of material, and much more worthy of study. After all, the very large majority of people *are* normal. Study of them will, then, benefit the greatest number. It will, presumably, be much more worth while, socially and economically, to aid such individuals in eliminating or avoiding their mental difficulties—every one has them.

We may even hope that, as in education interest has turned from study of the subnormal to study of the supernormal, so we may finally progress in characterology from the study of the mentally diseased and the feeble-minded to the study of the gifted and the genius. It may be possible to prevent the hampering emotional idiosyncrasies, or the mental or moral conflicts, which are so frequently seen in the lives of great men and women. Or, it may be possible to develop and nurture still more the powerful interests and enthusiasms of such individuals.

Such study will probably show that many supposedly abnormal features, in the histories of persons who are social or psychiatric problems, are not distinctive of abnormality at all. It will also probably demonstrate that many cases who were thought abnormal really are not; just as the testing done in the army has shown that many criminals and social delinquents who were thought to be feeble-minded cannot be so considered. In fact, a thorough revision of present concepts regarding mental disease may be expected.

The Average Family

In the first place, almost nothing is known regarding the "history" of the average family—that is, there is no knowledge of a systematic character, dealing with this topic as usually

investigated in the study of the abnormal individual. Practically nothing is known as to the incidence of feeble-mindedness and insanity in the average family. Every investigator does know this and that striking example of abnormality in a good family and when he stops to consider, he finds that he knows several such cases; yet "good" families conceal the presence of such members much more carefully than do "poor" families. Most investigators leave out of account such considerations, however. The writers hazard the guess that the average individual has in his family somewhere one or two persons who are mentally abnormal in some way. If this should be found true, evidently the appearance of one or two such people in the family of an abnormal individual cannot be given much importance.

Any experienced general practitioner knows many facts to bear out the above statements; in fact almost any one who has lived a number of years in a fairly stable community, and on reasonably gossipy terms with the neighbors, can produce evidence to support these contentions. There are many families which have "skeletons in the closet" in the way of a feeble-minded child who is kept in the house most of the time and then sent away secretly to a private school for defectives. Even more numerous are the families that have some member who is a chronic alcoholic or a drug addict, and who must be kept chronically under supervision. It is probable that most readers of this sentence have at one time or another had dealings with a person who had been "insane." It is quite likely, however, that even friends of the family did not know about this individual's mental upset—at that time the person "went abroad for his health," "took a rest cure in a sanitarium," "went for a trip to the South," or was otherwise removed from general observation. There are many cases of epilepsy about which no one knows except the family physician and the immediate family. Such individuals are closely watched and attacks anticipated to some extent, so that they take place away from the public gaze. Or, the attacks may be of a very mild

nature, perhaps occurring only at night, and so not recognized for what they are.

There is really very little known regarding the extent to which major physical diseases are to be expected in the average family history. For instance, in how many families is there a syphilitic member? Estimates vary as to the proportion of the total population who are infected.[1] It is evidently very important that such information should be made available.

Information regarding the more indefinite matters of the average family's social history is even more lacking. In how many families is there, or has there been, some member notoriously loose sexually? In how many families is there continual quarreling and bickering? In how many families has some member been in a reformatory or penitentiary,—or been brought before a court for some offense? How many families have been at some time dependent upon charity? What about the affiliations of the average family with church, lodge, or other organization? No one knows the answers to these questions.

Most investigators make much of the "broken home" situation, as a cause of delinquency, educational difficulty, and so on. But how many broken homes are there in the country at large? What is more important in this connection, how many children are there, from broken homes, who have *not* become delinquent? From almost every point of view (certainly from the scientific point of view), a social agency would contribute much more if it would occasionally pick a family at random from the directory, and investigate it so far as the answers to some of these questions are concerned, than is ordinarily contributed by studying further special cases. The writers would suggest such a study to any one wishing to undertake research in this total field as almost certain to prove exceedingly worthwhile.

[1] See, for instance, Hartman, W. L., "The Economic Viewpoint upon Syphilis in Industry," *J. of Industrial Hygiene*, Vol. V, pp. 341-346, January, 1924. It is estimated in this article that 20% of the general adult male population are infected.

The standing of the average American family educationally is probably lower than most people realize. The average American parents have probably not had schooling beyond the fifth grade.[1] What, in other respects, the cultural background of the average home may be, as regards reading matter for instance, is only a matter of surmise. Facts regarding the income of the average family are not to be had, at least in such shape as to be of much use for case-study purposes. The important thing to realize in all this is that almost nothing is known of the families of the millions of individuals who are never brought to the attention of some investigator. Under the circumstances it is impossible to say what the average family is like, and so impossible to say with any assurance that any family is abnormal.

The Average Life

When one turns to consideration of the history of the average individual one is astounded at the lack of definite information. For instance, in the study of abnormal individuals there is usually inquiry regarding falls resulting in head injuries; such falls are frequently reported and sometimes play no small part in any discussions of the case. However, the writers have found that at least half the men in college classes report they have had such head injuries at some time or other. Again, adequate information regarding the incidence of various diseases (as syphilis), is lacking. Information as to alcoholic indulgence on the part of "normal" individuals is not to be obtained.

Even about such elementary matters as the age of walking and talking, surprisingly little adequate information is available. The average time of walking and talking is known in a rough way, but (the important thing), the extent to which individuals who are to be considered normal show rapid or delayed development in these matters is not known. What

[1] This seems a conservative estimate for the parents, on the basis of the findings in the army at the time of the World War.

little data are available show that normal children differ greatly in these particulars.[1]

Ignorance regarding the social history of the average individual is colossal. For instance, petty thievery in childhood is looked upon as an important finding in studying criminals; but the majority of college students confess to childhood thievery of various degrees of seriousness. The writers are acquainted with a young woman now holding a doctor's degree who was haled into court in her childhood for setting fire to a barn in which the owner would not allow her to play. The frequency of such delinquencies in the childhood of perfectly normal adults is a matter about which practically nothing is known—and what is known points to a far greater frequency than one might suppose.

Incompatibility with one's family is another point always inquired after in history taking. Yet every one has at least one friend who is notoriously at odds with his whole family—root, stem, and branch. The commonness of such a feeling of antipathy is perhaps nowhere better evidenced than in the laughter evoked in any kind of theater audience by such remarks as "Well, you're given your family, but thank Heaven, you can choose your friends!" "Family Dissension" is surely not as important a social symptom as is sometimes thought: it is too common.

Perhaps most important of all, little is known about the sex experiences of normal children and adolescents. What investigation has been made [2] would suggest that most children

[1] See, for instance, Mead, C. D., "The Relations of General Intelligence to Certain Mental and Physical Traits," *Teachers College Contributions to Education*, 1916, No. 76.

[2] Some very valuable work has been done. The reader is referred to the following papers:

Wells, F. L., and Peck, M. U., "On the Psycho-Sexuality of College Graduate Men," *Mental Hygiene*, Volume 7, pp. 697-714.

Davis, K. B., "A Study of Certain Auto-erotic Practices" (in women), *Mental Hygiene*, Vol. 8, July, 1924, pp. 668-723.

Davis, K. B., "A Study of the Sex Life of the Normal Married Woman," *Journal of Social Hygiene*, Vol. 9, pp. 1-26, January, 1923.

Discussion of certain of these topics by such writers as Robie, W. F., *Rational Sex Ethics*, Richard C. Badger, p. 351, and Malchow, C. W.,

were "abnormal" sexually. Probably no matter has caused children and young people more worry than the practice of masturbation—with the usual accompanying agonized belief that they are ruining themselves physically, mentally, and morally. And yet investigation would seem to show that a large majority of individuals have masturbated more or less at some time in their lives, usually with no demonstrable ill effects.[1] Sex play among children is certainly not uncommon, yet it is usually looked upon as a sign of utmost depravity; the writers know of one instance where a child of eight was disinherited because he openly, without understanding of the nature of the act, imitated another boy in such a practice. It is reasonably certain that most adolescents have decided homosexual feelings at times. And sexual intercourse between adolescents is surely not limited to the few who happen to get caught. Yet, such sex delinquencies in the histories of delinquent girls are commonly regarded as indicating extreme lack of moral control. In general, almost nothing is known about what constitutes a "normal" sex history.

One frequently finds school psychologists, and others who are called upon to investigate children, who regard any deviation from docile conduct during the period of adolescence as a matter of concern. Thus, the boy who suddenly loses interest in school, who runs away from home, who spends his time hanging around the corner drug store, who is impudent to his parents, and so on, is likely to be considered as showing abnormal behavior. And yet what healthy adolescent is not more or less at odds with his family and environment? Many workers lose sight of the fact that the period of adolescence is

The Sexual Life, C. V. Mosley Co., p. 306, will serve as a much needed antidote for the older scarehead type of sex literature.

[1] Where harm has actually resulted this has almost always been because the practice was indulged to excess, because the individual was neurotic in the first place, or because of worry about the matter; such worry often appears to do much more harm than the practice itself. In pathological cases excessive masturbation is to be regarded more often as a symptom than as a cause. . . . The practice should always be prevented so far as possible—of course. But the problem should be met with calm common-sense, not an emotional flurry.

84457

one of unrest and of blind groping after some kind of change. An occasional outburst is probably more typical of the normal adolescent than of the abnormal.

About the average educational history, of course, more is known. The usual mistake here, as elsewhere, is that the investigator is likely to have too high a standard. A grammar school education is all that can be expected of the average individual, although standards in this respect are constantly rising.[1] The economic status of the average individual is again not known as it should be. How often does the "normal" person change jobs? How frequently is the normal person in debt? It is sometimes stated that 90% of business men fail, at some time. A very large proportion of automobiles are bought "on time." . . . There are numerous evidences that the average individual is by no means uniformly successful nor always out of debt.

The Examination of Average Individuals

Perhaps the most astounding result of the use of intelligence tests in the army was the discovery that the average adult had a mental age of about 14, as determined by these methods,[2] and that the standards for judging mental defect had to be very definitely lowered. A few years ago the writers saw diagnoses of subnormality made on the basis of a mental age now known to be above average.

It is well known also that the army physical examination showed various abnormal physical conditions to be much more frequent than had previously been recognized. Analogous data are also rapidly accumulating for school children. Apparently, about 30% of the older school children have visual

[1] Thus in 1890 apparently not over one in ten children reaching their teens in the United States entered high school, whereas at present about one in three children entering their teens thus begins a secondary school education. (For a valuable discussion of this situation see Thorndike, E. L., *The Psychology of Algebra*, Macmillan, 1923, Chap. 1, "The High School Pupil.")

[2] See, for instance, Brigham, Carl C., *A Study of American Intelligence*, Princeton University Press, 1924, p. 210.

defects, around 5% have defects of hearing, around 40% have decayed teeth, about 20% have diseased tonsils and around 10% adenoids. It is difficult to state definitely the per cent of under-nourished children, but the number is large. It may almost be said that the average child shows some defect upon physical examination.

If all these things are true with regard to intellectual level and physical condition, it seems entirely reasonable to suppose that an examination covering the emotional condition of average individuals would lead to similar widening of the limits of normality. Practically every one has emotional conflicts.

It should be realized that conflicts may manifest themselves in a great variety of ways. A child (or adult) who has some desire which is opposed may daydream, and secure satisfaction in his imaginings. This is more or less of a common device with most people. According to temperament one may imagine himself as a hero who does what one wishes to do; or one may indulge in a somewhat different way by imagining great misfortunes for oneself which result in sympathetic attention. Daydreaming is a convenient outlet for suppression and conflict, in fact; by encouraging people to tell of their daydreams important facts concerning conflicts may be brought to light. Satisfaction of a suppressed craving may also be found by identifying oneself with some person who does obtain gratification of his desires; hence the interest in fiction and in the movies. A conflict may result in a general instability of mood which manifests itself in situations and toward persons totally irrelevant to the cause of the difficulty. A "sour grapes" reaction should also be understood in its real significance; thus a college lad who has failed to "make" a fraternity may become very disparaging (or hostile) to such organizations, saying that they amount to nothing, anyway. A final type of reaction which may be the result of conflict may be found in "rationalizing" one's way out of a situation. Thus an acquaintance of the writers is morbidly afraid of small closed spaces. She recently purchased an open car; her private confession is that this was due to her claustrophobia. However, she rationalizes her purchase elaborately to her friends, saying that an open car is cheaper, is more pleasant and airy for tour-

ing, and is really more stylish and distinctive since closed cars are now so common. . . . In short, emotional conflicts and emotional difficulties more or less "abnormal" are very common; but the symptoms of such conflicts are usually not recognized.

There are many normal people who are decidedly over- or under-emotional. Surely enough people have outbursts of temper and periods of stubbornness to make episodes of this sort of relatively slight importance in the diagnosis—unless such episodes are indulged in to excess. It is also to be remembered that, under unusual circumstances or in times of crisis, average individuals may very often behave in unusual ways.

Many investigators forget that most people are not used to mental and physical examinations and so behave in somewhat unusual ways when being examined. It should be remembered that most examinations are given to people who know they are under suspicion. For instance, if a boy is suddenly sent for by a school principal, and if the boy has to leave his classroom amidst the giggles of his mates, has to wait ten minutes while the principal talks to some one else, and sees another boy come out of the office crying, it is not to be supposed that his emotional reaction will be perfectly "normal" whether he is guilty of some offense or not. Much more is some special attitude to be expected from an individual who has been arrested, even although entirely innocent of any crime. And it is interesting to speculate as to the type of emotional reaction, in a general mental examination, which would be shown if a person here and there on a city or village street were suddenly taken to a hospital for the insane and put through the usual inquiry.

The consideration raised in this chapter should be of some comfort to the self-conscious individual who (the type is very common) feels he is much more morbid, peculiar, or incapable than most people are. It must be realized that educational,

social, or economic difficulties cannot be easily passed off as due to some pathological mental condition if one can only find some sex delinquency, some childish thieving, some adolescent outbreak, or bit of emotional maladjustment, some retardation in school. The following conclusions seem reasonably probable with regard to the average individual. (1) His family is likely to show at least one insane, feeble-minded, epileptic, alcoholic, or syphilitic individual in the near ancestry. (2) The individual's own history is not to be considered unusual if he did not finish grammar school, if he was shown to have been involved in a few childish thefts, to have masturbated occasionally during childhood, to have had some adolescent sex experience, to have changed jobs somewhat frequently, to be in debt, or to have quarreled with his family. A similar common-sense point of view should be taken toward other facts gathered in a case history. (3) An individual cannot be considered necessarily abnormal if he shows an I. Q. of 80 (or if an adult, a mental age of 12), supposes it is Tuesday when it is really Thursday, cannot name the first president, appears slightly flighty or lacking in judgment, appears with no collar and a dirty shirt, or if he shows a suspicious attitude toward the examiner.

All of these things may be abnormal for people of the investigator's social class; but if the total population of the country should be considered, the writers venture the opinion that these "symptoms" may not be so judged. It is necessary to consider the standards of the social, economic, and racial group from which the individual comes (and to consider these standards broadly), before judgment can be passed regarding the significance of a "symptom."

Because of the lack of study of the "normal" individual, it has been difficult to find case studies in the literature. However, one of the writers has made it a practice to request all members of his classes in Abnormal Psychology to hand in case studies of persons whom they have known. From these,

and from observations of people they have themselves known, the writers have selected the five studies given below as fairly indicative of the wide range of mental or emotional peculiarity that may exist among people who seem essentially normal.[1] These individuals have all (with the exception, of course, of the twelve-year-old boy first mentioned) demonstrated their ability to meet all the requirements of a successful adult life; they are now respected and self-respecting members of their communities, doing their work well and adjusting themselves satisfactorily to those with whom they come in contact. Nevertheless these five persons have all shown certain rather striking anomalies of character or intellect. Cases 2 and 4 show histories of physical illness during childhood which are doubtless of importance;[2] but such histories appear not uncommon. The point to be noted is that both these cases have shown abilities and achievements very decidedly above the average. Yet there were periods in the lives of these two young women when, if they had been brought to the attention of a psychiatric clinic of ten years ago, and judged by the clinical standards of that time, they would probably have been considered definitely pathological and given a poor prognosis. In the first two cases, the child was distinctly without home control or discipline. Case 3 is an illustration of economic and social adjustments successfully made by a man certainly below average in intelligence. It surely seems not justifiable to consider the man feeble-minded; yet he would have probably been so judged, if brought to a clinic in his youth. Case 5 is a very peculiar instance of family dissension. Yet it caused no particular annoyance to any one, and led to no disturbances.

[1] As a matter of fact all the cases reported in this chapter were known by one or the other of the writers to some extent—certain cases were known intimately. To avoid painfully ready identification of a case by any reader who might know one of them, the writers have here (and throughout the book) altered certain details of an incidental nature. But every case in this volume is a real case—and the essential facts were as given.

[2] It is now known that often chorea and infantile paralysis leave conditions of emotional irritability which are more or less permanent. These two cases thus do not, perhaps, belong in this section. Nevertheless their abnormalities appear very consistent with the histories of other members of their families who did not suffer from such childhood diseases; and others the writers have known, who have had these diseases, did not show such conduct disorders. So it appears not unreasonable to consider these two cases as illustrating anomalies of conduct which may appear in normal individuals.

Neither the man nor the woman was looked upon as abnormal by friends or employer. In their general social and economic relations their lives were not unusual.

CASE No. 1

Name: John F. *Age*: 12. *Sex*: Male. *Race*: White. *Birthplace*: Massachusetts. *Sources of information*: the boy himself; mother, father, school principal, policeman, court record.

I. History of the Family.
   A. Medical—Nothing abnormal or unusual found.
   B. Social—Father, who is a successful physician, has for some years lived with a nurse to whom he is not married. He maintains his wife and family in comfort, but lives in another apartment with the nurse. His wife seems well satisfied with the arrangement, as she has all the money she needs. Mother spends most of her time shopping, playing bridge, etc.
   C. Educational—Mother a high school graduate; father, college and medical school training.
   D. Economic—Mother is a society woman; father, a very successful physician.

II. History of the Individual.
   A. Medical—Developed more rapidly than normal. Talked at 1 year, walked at 11 months.
   B. Social—Has always stolen things. Has systematically practiced picking pockets and opening locks. Never does any kind of rough work for fear he will destroy the sensitiveness of his touch. Is suspected of juvenile sex experiences.
   C. Educational—Does excellent work in school; has always stood at the top of his class. Is anxious to get a good education. Is well behaved, but somewhat "slick," in school.
   D. Economic—Nothing.

III. History of the Present Crisis.
   A. Medical—Nothing.
   B. Social—Was caught in an attempt to pick a man's watch from his pocket. A policeman saw him do it; the owner had not noticed the loss. Was entirely possessed in court. Said he intends to become a gentleman pickpocket—a sort of "Raffles."
   C. Educational—Nothing.
   D. Economic—Nothing.

IV. Present Condition.
   A. Physical Condition.
      General Condition; fine healthy boy.
      Special Defects—None.

B. Appearance and Behavior—Is slightly underactive for a healthy boy. Is extremely sophisticated in his speech and "slick" in his appearance. Says that "good" people never have any money and that money is all that counts, that honesty never leads to anything but the poor house—and so on. His clothing is in the extreme of fashion for boys four or five years older than himself. Seems greatly bored with the whole affair.

C. Intellectual Condition.
General Level—Has an I.Q. of 135. Very quick and alert.
Special Functional Disorders—Nothing of importance, except that his thoughts center definitely around his ambition rather more than one would expect of so young a boy.

D. Emotional Condition.
General Emotional Tone—Appears somewhat indifferent and slightly apathetic. Evidently scorns any show of emotion.
Special Emotional Trends—Nothing.
Emotional Conflicts—Impossible to elicit anything.[1]

V. Summary and Conclusions.

A. Summary—An unfortunate and upsetting home condition. Persistent delinquency and an anti-social ambition in an unusually intelligent boy. An extreme of sophistication and boredom, for his age.

B. Conclusion—A normal boy whose parents show persistent disregard of and indifference to accepted rules of conduct, and whose behavior is probably best understood as one way or another a product of these unfortunate home conditions.

Case No. 2

Name: Mary L. *Age*: 27. *Sex*: Female. *Race*: White. *Birthplace*: small city in New York State. *Sources of information*: girl's own remarks about herself; chums, mother, older brother, present employer. college records, a next door neighbor, and old friend of the family.

I. History of the Family.

A. Medical—Unusually healthy family.

B. Social—Mother reported to have been "rather wild" in her youth. One brother "disappeared" for several months and has since refused to tell where he was. Home was comfortable, but lacking in discipline. The children did as they pleased. The family was rarely together at mealtimes, each

[1] Brooding over his father's manner of living and his mother's indifference towards himself may conceivably be at the bottom of the boy's troubles. But every effort to get at such factors failed.

one eating when he got around to it. The mother was very active in club and church work, and away from the house much of the time.

C. Educational—Parents had only grammar school education. Brothers and sisters finished high school. One brother is college graduate.

D. Economic—Father is "boss" in a large factory. One brother is a clergyman.

II. History of the Individual.

A. Medical—One attack of chorea when twelve years old, otherwise unusually healthy; strong and overflowing with energy.

B. Social—Always has done as she pleased. Has had many childish sex affairs. Was considered by other children to be rather "tough." Was excitable and boisterous. Had very few friends. Was out late evenings, even in early childhood, walking the streets, but was never suspected of any real delinquencies. When 12 or 13 years of age she went to school to a married man of about 40. He made much of her, as she was his best pupil. He maintained a rather large household and secured a position for her to work as maid during one summer. He soon started immoral relations with her. She has been intimate with him from time to time ever since. Once stayed out of college for a year to be with him. Is still unmarried and is living near him, although no open immorality seems to exist at present. She is, nevertheless, shunned by those who have known her history.

C. Educational—Took high school course in three years; completed college course in another three years. Always stood at the top of her class.

D. Economic—Worked her way through college by waiting on table. Now has an excellent position as private secretary. Employer says she is the best secretary he ever had. Is able to take dictation and transcribe her notes in four languages.

III. History of the Present Crisis—There has been none, as the girl has always been able to adapt herself to her environment.

IV. Present Condition.

A. Physical.

General Condition—Is a robust, handsome girl, full of vigor and energy.

Special Defects—None.

B. Appearance and Behavior—Gives an appearance of great efficiency. Has erect and graceful carriage of the modern athletic girl.

C. Intellectual Condition.
General Level—Has never been given an examination, but some idea of her intelligence may be gained from the fact that she taught herself Greek grammar and read the "Anabasis" during her spare time one summer—and passed a college entrance examination on the material in the fall. Could memorize a poem of four stanzas in a single repetition.
Special Functional Disorders—All mental functions excellent.

D. Emotional Condition.
General Emotional Tone—Normal.
Special Emotional Trends—Nothing of importance.
Emotional Conflicts—No evidence of any. No apparent regret over past actions. No feeling of inferiority.

V. Summary and Conclusions.

A. Summary—A disorganized home, containing other individuals who have had something of a "fling" in their youth and in which the children had almost no supervision or guidance. Unruliness, boisterousness, and "toughness" (including some sex experiences) in childhood. A moral degenerate who influenced her to allow him any privilege he wished. Superior intelligence; more than average physical vigor.

B. Conclusions—An unusually bright girl, whose emotional life has been blunted by environmental conditions. Normal.

Case No. 3

Name: Gordon M. *Age*: 26. *Sex*: Male. *Race*: White: *Birthplace*: New Hampshire. Married, one child. *Sources of information*: a near neighbor who is an experienced probation officer and very shrewd in his estimate of people, mother, two of the individual's former teachers, employer.

I. History of the Family.

A. Medical—Father is probably feeble-minded—moron (see educational and economic history following). Younger brother certainly is (now twelve, I.Q. 56, in special class). The one child is only a year old and seems about like other babies of that age.

B. Social—The members of the family have always gotten along well with each other and the neighbors; the father in particular is always good natured and obliging, and is generally liked.

C. Educational—Mother finished high school, but father, though he was born and grew up in a small New England town, cannot read or write.

D. Economic—Father had a good, small, independent business left him by *his* father, but was unable to carry it on. Now runs an elevator.

II. History of the Individual.
- A. Medical—Walked at 16 months, talked at about two years.
- B. Social—Never played with other children very much. Always went home after school to play violin or 'cello. Is rather proficient upon both instruments although his playing lacks expression.
- C. Educational—Was unable to finish grammar school although he tried hard and attended until he was 17. Had been carried along to the seventh grade, but was painfully inadequate to the work of that grade. He required several years of drill to learn to read music. He still reads very slowly. Married the girl who sold tickets at a movie house.
- D. Economic—Is now a 'cello player. Is steady and faithful, and is never out of a job. Plays in movie houses and theater orchestras.

III. History of the Present Crisis—None.

IV. Present Condition.
- A. Physical.
  General Condition—Health excellent.
  Special Defects—Very expressionless and somewhat asymmetrical face.
- B. Appearance and Behavior—Is quiet, talks very little. Always polite and pleasing in manner. Moves very deliberately and with considerable awkwardness. Is indifferent toward everything except his music and family.
- C. Mental Condition.
  General Level—No examination ever given, but a few questions somewhat like certain tests of the Binet, worked into a conversation, suggested a mental age not above eleven. This is in accordance with one's general impression of him.
  Special Functional Disorders—Nothing striking; but his memory for school work seems very poor and his association slow.
- D. Emotional Condition.
  General Emotional Tone—Rather stolid and apathetic.
  Special Emotional Trends—Nothing.
  Emotional Conflicts—Nothing.

V. Summary and Conclusions.
- A. Summary—Father probably feeble-minded, younger brother feeble-minded. Failing seventh grade when he left school at seventeen. Asymmetrical face, awkward, memory for school work very poor.
- B. Conclusions—A low normal, or high-grade feeble-minded man who has been able to so adjust himself to his environment that he appears practically normal.

CASE No. 4

Name: Marion R. *Age*: 34. *Sex*: Female. *Race*: White. *Birthplace*: Massachusetts. Married, 3 children. *Sources of information*: "patient," father, aunt, family, doctor, husband.

I. History of the Family.
   A. Medical—Mother's father and two uncles on mother's side chronic alcoholics, and several times in state hospital for the insane. Uncle on father's side a dementia præcox case, was brilliant but eccentric; an inventor whose inventions paid him enough to support him and his wife for the rest of their lives. Another uncle very eccentric. One cousin feebleminded. Mother died at patient's birth. Father died of a shock.
   B. Social—Harmonious family. Strict discipline.
   C. Educational—Father and the two brothers all have college education.
   D. Economic—Father was high school principal, one brother lawyer, the other a doctor.

II. History of the Individual.
   A. Medical—Sick from infancy with poor digestion. Had very mild attack of infantile paralysis when two years old. Suffered also probably from rickets. Had insomnia; subject to nightmares when able to get to sleep. Has had attacks of a somewhat undefined character when she had to be held down on the bed and fed forcibly. Was too sick to attend school regularly.
   B. Social—Stole all sorts of small objects. Was almost never caught. Always played with boys. Began having sex experiences at 7 years and continued until adolescence. Lied in preference to telling the truth, just to "fool people." Had terrific outbursts of temper in which she would break anything she could get her hands on. Was noisy, boisterous, and destructive. Once set fire to a barn. Was expelled from school for stealing.
   C. Educational—Went through college, although never very well. Graduated with honors.
   D. Economic—Became successful professional woman. Has married and has three healthy children.

III. History of the Present Crisis—None.

IV. Present Condition.
   A. Physical.
      General Condition—In good condition, vigorous, but still has weak digestion.
      Special Defects—None.

B. Appearance and Behavior—Somewhat overactive. Has several pronounced tics. Talks rapidly and a great deal. Gestures frequent and vivid.
C. Intellectual Condition.
General Level—Very high. Learns with great speed and retains remarkably. Once learned a three page poem in two readings and could repeat it eight years later.
Special Functional Disorders—Nothing.
D. Emotional Condition.
General Emotional Tone—Somewhat excitable and irritable; no marked peculiarities.
Special Emotional Trends—Nothing.
Emotional Conflicts—Nothing.

V. Summary and Conclusion.
A. Summary—A family containing many unusually capable and also many very eccentric individuals. Bad start physically in childhood. Many childhood delinquencies, possibly due to physical condition. Superior ability.
B. Conclusion—Normal woman, with considerable early physical handicap, probably due primarily to childhood diseases.

Case No. 5

Name: Nora B. *Age*: 61. *Sex*: Female. *Race*: White. *Birthplace*: England. Married, one son. *Sources of information*: man and wife, neighbors, family doctor, nurse, housekeeper, son.

I. History of the Family.
A. Medical—Nothing unusual known.
B. Social—Nothing unusual known.
C. Educational—Apparently average education for English middle class people.
D. Economic—Appear to have been fairly well-to-do people in rural England.

II. History of the Individual.
A. Medical—Nothing unusual.
B. Social—Has not spoken to her husband for 20 years. He has not spoken to her. They both talk to their son, but never to each other. Each one seems fond of the other. She prepares such food as her husband likes, mends his clothing, takes care of his room, nurses him when he is ill, and is very thoughtful of his likes and dislikes. He is equally thoughtful of her. They made a vow not to speak to each other some twenty years ago after a quarrel, on the basis that future quarrels might thus be avoided.
C. Educational—Grammar school education.
D. Economic—Efficient housewife; house neat and clean.

III. History of the Present Crisis—None.

IV. Present Condition.

A. Physical Condition.
General Condition—Rather frail woman, some signs of senescence (gray hair, slight tremor in hands).
Special Defects—None.

B. Appearance and Behavior—Normal, except for behavior toward husband.

C. Intellectual Condition.
General Level—Appears to be normal in intelligence.
Special Functional Disorders—None.

D. Emotional Condition.
General Emotional Tone—A little bit excitable, but otherwise normal.
Special Emotional Trends—None observed.
Emotional Conflicts—Probably something in the past, but it seems to be too far back, and the woman too old, for any adequate analysis.

V. Summary and Diagnosis.

A. Summary—Lives with her husband, but has not spoken to him directly for about twenty years, otherwise nothing abnormal appears in the case study.

B. Conclusion—Normal woman with some emotional upset (probably) sometime in the past, which has left behind it a defensive attitude toward the husband.[1]

[1] This old couple died recently. The man died after a rather long illness during which his wife waited on him but never spoke. The day after his death she had a complete collapse and died in a few days, apparently of a broken heart.

CHAPTER VII

THE "BORDERLAND" CONDITIONS

The present chapter deals with certain conditions which because common and frequently not recognized for what they are, because a major source of economic waste and unhappiness, and because in the majority of cases preventable, should be thoroughly understood—especially by those having to do with children and adolescents, since it is ordinarily in childhood and adolescence that such difficulties both have their origin and can be most readily dealt with.

The great frequency of these unfortunate mental and emotional states, and their importance in everyday living, cannot be too strongly emphasized. There is no problem of health more insistent. In most families there can be found (and that without searching among the very distant relatives) at least one neurotic member. And these difficulties of mental and emotional health, though subtle and not easy to understand, are very real indeed to those thus handicapped. Dr. Mayo's statement (mentioned in the first chapter), that these conditions in the aggregate cause more human misery than tuberculosis or cancer, is probably no exaggeration. Further, these mild forms of mental illness have an uncanny knack for disguising themselves and appearing to the casual observer as a more or less vaguely defined physical illness, or in terms of some sort of social or economic difficulty. It should be appreciated that the types of cases to be presented in this chapter are not ordinarily to be found in a hospital, at home in bed, or otherwise unmistakably designated as ill. Most of them are never diagnosed for what they are at all. These people

are to be found instead in a doctor's office complaining of some emotionally developed or entirely imaginary physical symptoms, in factory or business house as pathologically fatigued or irascible and trouble-making workers, in the office of the high school principal or college dean for failing work or persistent infraction of rules, in court or social agency for family incompatibilities, or otherwise in trouble. In short, these "borderland" cases are an ever-present problem, and are found as a factor in almost every other large human problem. Such cases are often very difficult to understand. But if the reader can come to some comprehension of these people, he will find that he has obtained insight for dealing with a variety of questions, many of which might at first seem not at all related to this subject.

It is evident that to speak of these conditions as "borderland" hardly describes them in any very determinate fashion. But the term should at least make clear the close relationship of these conditions to both normality and frank mental disease. The various types of borderland states which will be mentioned also merge into one another. One might almost say, in fact, that the important thing to remember is not the classification, but rather the fact that this classification holds only in a very general way.

The complexity and variety of these conditions must be constantly kept in mind. In some instances the mental abnormality appears to be largely secondary to a physical difficulty. So emotional peculiarity may appear largely a result of a condition of anæmia and under-nutrition. Or marked emotional instability may seem quite obviously the product of glandular disorder or of chronic infection. In other instances the mental condition seems fully explained on the basis of very unusual emotional stress; the individual appears to be essentially a normal individual who has been swept away or gradually worn out or twisted by handicaps so severe as to affect almost any one. (It must be realized in this connection that emotional stress keeps the whole organism in an abnormal physical condition.) It must finally be remembered that many of these borderland conditions are so mild that authorities

differ as to whether a given case should be considered abnormal or not.

However, though classification is very difficult, and each case largely a law unto itself, there are certain quite definite types which it is helpful to keep in mind, in studying cases. Most of these borderland conditions may, in fact, be grouped under three main heads: an individual is (a) emotionally maladapted, (b) emotionally unstable, or (c) mentally peculiar. He may show evidences of all three of these conditions. But one type of difficulty usually dominates the picture and gives warrant for the classification.[1]

In considering these types—in fact, in considering all the types of individual taken up in this section of the book—a rather rigid scheme of presentation will be adopted. This scheme very closely resembles the plan of the case-study outline and may, therefore, easily be remembered. The effort will be to present the general facts about a certain type of individual much as an investigator would go over these points in considering an actual case. The first thing to be considered is the more or less typical heredity of the class of persons under discussion; then the usual history of an individual belonging to the class will be discussed; then will follow a consideration of the sort of thing that brings on the immediate crisis, with a description of the typical physical and mental conditions found upon examination. Finally, a word will be said about treatment and prognosis.

The Emotionally "Maladjusted"

Under the first general head—the "emotionally maladjusted"—are included three types of condition; these types are frequently referred to as the "psychoneuroses." They are (1) "neurasthenia," (2) "hysteria," and (3) "psychasthenia."

The typical heredity found in all three of these types is more or less similar. In fact, it is somewhat like the heredity in any

[1] Two other and much more obvious borderland types will be touched upon later. The "borderland feeble-minded"—subnormal and constitutional psychopathic inferior—will be mentioned in Chapter X. And cases where mental difficulty is secondary to physical ill health (referred to above) will be returned to in Chapter IX.

other "borderland" person; there is a "borderland" heredity. One may often find evidences of that constitutional weakness which furnishes the soil in which the neurotic condition most readily develops. There are likely to be other persons in the family who are rather like the patient. There will probably be occasional evidences of real mental disease. Other relatives will probably be reported as "queer." One gets the impression of a family composed of people having a little too much individuality, and perhaps rather lacking in self-control or else somewhat too repressed. One usually has the further impression of a somewhat strained and unnatural home life. And it is impossible, in most instances, to tell whether the patient's difficulty is a product of these intimate home conditions, or whether the patient, *and* his family, are evidences of a neurotic family stock.

Out of this abnormal home and family situation the neurotic comes. He is likely to be not any too strong physically, to be a person who overreacts to physical disease and recovers slowly. As a child he was very likely often ill or ailing, though the nature of the illness was frequently not clear. School work has often been good; and one may get the impression that the individual's earning capacity is fundamentally excellent, though interfered with by the neurotic condition. There are almost certain to be difficulties in social adjustments; superficially there may seem to be no difficulty, but things do not go easily or comfortably. Very likely during childhood the person was considered somewhat "odd"; and later social adjustments are likely to be of an artificial and conscious sort. There may be records of emotional outbreaks, or the suggestion of morbid emotional repressions.

A person coming of such a family, and in such a condition as described above, is evidently poorly prepared to withstand any added strain or shock. His reaction to the final difficulty will depend partly on the nature of the difficulty and the way in which it comes upon him—whether suddenly or gradually—but more upon the individual's make-up and reactions to date.

In fact, there may be no obvious added difficulty at all; the person simply breaks under a long-continued emotional burden, the real difficulty being that there is no change and appears to be no hope of one.

It should be emphasized that these conditions begin in childhood and in many cases at least are to be thought of as definitely a product of unfortunate childhood experiences, training, or surroundings. In so far as this is the case it is evident that early diagnosis of such cases is desirable and that every effort should be made, as soon as difficulties appear, to deal with them at once. Where the fundamental cause is physical condition in childhood, it is of course equally desirable that there be early diagnosis and treatment.

Underlying emotional difficulties which are the root of the neurotic condition are often sexual; so the child may have learned of sex practices from some degenerate adult (or from an adult in his own family), worries, finds that sex has a fascination, is afraid to talk over his ideas (or is still further repressed when he attempts to do so)—and finally a morbid emotional state is developed poisoning the child's whole existence. Emotional conflicts are by no means always sex affairs, however. Humiliation in connection with the family's position in the community, or other difficulties, may so operate. Finally, the stress which pushes an individual into the final crisis may have no relation to the original cause of the neurosis. The child may have failed in school, may have been disciplined by a teacher, may have been greatly frightened by some experience or may have been ill; these incidents act simply as the last straw—but are frequently regarded by the child's parents as the cause of all the trouble.

Neurasthenia. If the individual is naturally somewhat repressed, overcautious, overanxious, lacking in vigor, introspective and rather solitary in his habits, his difficulties will probably lead to *neurasthenia.* The immediate cause in this instance is likely to be a prolonged emotional strain over troubles not easily finding expression. The person is one who does not readily turn his mind to other matters and is lacking in outside interests. Consequently, there is more and more emotional preoccupation until the whole mental life has become emo-

tionalized; there is a subtle feeling of discouragement and dissatisfaction and hopelessness. There is, almost inevitably, insomnia, and a feeling of great weariness, a lack of physical energy. There have probably been disturbances of a digestive nature. And there is finally a condition which is characterized most obviously by fatigue symptoms. However, the fatigue (which may be an actual prostration) is out of all proportion to the immediate cause. In fact, one sometimes has the impression that there is a conscious exaggeration of the symptoms of physical fatigue—a definite hypochondria. The situation can be understood only if one realizes that the immediate cause is *not* the important cause of the collapse—it is the constant dragging emotional dissatisfaction that has finally worn the person out.

The patient shows, then, primarily symptoms of emotional exhaustion. Physically there are insomnia, headaches, dizziness, irregular pulse, and digestive disorders—especially lack of appetite and constipation. Emotionally, there is either irritability or an emotional exhaustion which has progressed to a settled mild melancholy. The patient is usually of fair to good mentality; but his thinking is constantly preoccupied with his emotional discomfort. There is great difficulty in centering the attention on matters not related to the emotional problem, and the patient becomes easily exhausted by any sustained effort at attention. Memory for facts not relevant to the emotional difficulty is poor, because of the lack of attention to these facts. The flow of ideas is likely to be rather slow. The patient is usually very sensitive to sudden, distracting lights or sounds. His movements are slow and effortful, and markedly lacking in spontaneity. His manner is likely to be listless or forced; there may be carelessness about dress and cleanliness.

Well—many of us have been in such a condition at one time or another, as a result of emotional stress. The typical neurasthenic differs from the average individual in two particulars: the nature of the emotional stress is less obvious; and his

reaction is excessive. Evidently, the treatment must consist in the elimination of the cause of the emotional difficulty and in a general building up of a physical well-being and of new interests. One may, then, hope for a cure of the immediate difficulty in proportion as the situation can be thus changed. But one may expect similar difficulties to appear later in proportion as the individual has settled bad habits of emotional repression and is lacking in emotional hardihood or is constitutionally morbid. So with the first return to a condition of reasonable vigor a process of reëducation should be begun, which should better fit the individual for meeting any further periods of stress, and should acquaint him with his own weakness so that he may learn to avoid stress where this is possible.

In children, neurasthenic conditions are often very obviously related to physical disease; the child is anæmic, or undernourished, or suffering from some chronic infection as in the tonsils. Or there may be conditions putting a limit on physical activity, as asthma or chorea. A neurasthenic attitude in later life may be the product of such purely physical conditions; the individual becomes hypochondriacal and, because of his childhood illnesses, fails to develop physical or social self-confidence. In such cases treatment must evidently center upon the establishment of physical vigor—it is interesting that the maintenance of physical health during childhood is of great characterological as well as physiological importance. In other instances, however, the condition is almost wholly a product of an emotional problem. And since the problem is of a very intimate personal nature the great difficulty is in finding out about this problem.

The two case studies presented below may be considered as fairly typical of neurasthenia. It will be noticed that both of these people are caught in situations they cannot get away from. The natural reactions to their situations involve emotional attitudes which constantly conflict, and desires chronically unsatisfied.

The last case given is very typical of the condition of many middle-aged Jewish women. Their difficulties come through a

lack of adjustment to their new environment; this adjustment their husbands and children have made. At middle age they find themselves completely out of sympathy with their environment and become worried, anxious, and finally neurasthenic. Their troubles are probably not inherent in the race, as some workers with whom the writers are acquainted have affirmed, but are more probably the results of a problem of adjustment to a new—and very different—environment.

Case No. 6

Name: Mary S. *Age*: 19. *Sex*: Female. *Birthplace*: Ohio. Single
Sources of information: girl's story, father, stepmother, a friend, the family doctor.

I. History of the Family.
   A. Medical—Mother died at child's birth. Mother's family all rheumatic.
   B. Social—Following mother's death, father drank and gambled. After ten years he married again. Since then the family has been divided, the father and daughter against the stepmother and her daughter.
   C. Educational—Mother and father high school graduates.
   D. Economic—Uncle, professor in university. Father owns best dry goods store in town.

II. History of the Individual.
   A. Medical—Has always had poor digestion.
   B. Social—Up to ten years of age, seemed to have the normal number of friends in school. Since arrival of stepmother, her home has been too unpleasant to ask friends to visit her, so she has lost most of her friends.
   C. Educational—Finished second year of high school.
   D. Economic—Taught a country school for a year. Since then has helped her father as an extra clerk in his store.

III. History of the Present Crisis.
   A. Medical—After father's remarriage she began to complain of headaches and backaches and stomach trouble. The difficulties seemingly increased until she was unable to do any work and became confined to her room and then to her bed. But as she got scant attention from her stepmother, it was sometimes necessary for her to go down to the kitchen to get something to eat. She was always able to do anything like this that she desired.
   B. Social—When teaching she became acquainted with a young man in the country, who sometimes came to see her on week ends, but as she was always so tired that she couldn't get

out and walk or ride much, and her stepmother made it disagreeable and impossible for them to have any privacy in the house, he soon ceased coming. She made a few friends when she taught in the country and when she worked in her father's store, but they did not care enough about her to come to see her, especially after she became bedridden. Two of the most noticeable characteristics of the girl were her loathsome feeling towards cats and her bitter hatred of her stepsister, whom she could not bear the sight of. Her stepsister was having all the advantages that her stepmother could give her.

C. Educational—None.

D. Economic—Spent her time doing nothing or reading "Snappy Stories," and similar literature. But every day she wrote many pages in her diary. This she kept locked in her desk and allowed no one to read. She has been so ill that she could not do any work.

IV. Present Condition.

A. Physical.

Is exhausted; has indigestion and constipation, no appetite. Is without energy or vitality. Seems too weak to get out of bed.

No special defects.

B. Appearance and Behavior—Lies in bed dressed in very expensive robes and wants everyone to wait on her. Cries very easily. Reads a little, but for the most part lies still.

C. Intellectual Condition.

General Level—I.Q. of 90.

Special Functional Disorders—Judgment is very much preoccupied with her emotional life and her physical symptoms. Her mind seems entirely centered on her tiredness. Attention—cannot concentrate. Says she is always "too tired" and not interested in anything. Memory—normal. Association—normal. Intake—normal.

D. Emotional Condition.

General Emotional Tone—Childish, fretful, unstable, and irritable.

Special Emotional Trends—Extreme jealousy of stepsister.

Emotional Conflicts—Is evidently unable to compete with stepsister who is more alert and capable than patient. There is every evidence of conflict over this home condition. The patient seems to have resolved the conflict by starting competition for attention along an entirely different track (appeal for sympathy, through illness), since she has not been successful in any other way. Is withdrawing from reality after finding herself incapable of environmental adaptation.

V. Summary and Conclusions.
   A. Summary—Headaches, dizziness, exhaustion, stomach trouble, constipation, family dissension, jealousy of stepsister, economic inefficiency, emotional preoccupation, emotional conflict with resulting withdrawal from reality, weak attention, marked lack of energy or ambition.
   B. Conclusion—Neurasthenia.

Case No. 7

Name: Naomi S. *Age*: 56. *Sex*: Female. Birthplace in Russia. Married, 11 children. *Sources of information*: own story, husband, a married daughter in whom her mother has confided, hospital outpatient record.

I. History of the Family.
   A. Physical—Normal, so far as known.
   B. Social—Ancestors have lived in Jewish ghetto in Russian city for generations.
   C. Educational—Not known.
   D. Economic—Lower middle-class Jewish family.

II. History of the Individual.
   A. Physical—She has had eleven children.
   B. Social—Came to America at twenty-five years of age and settled in tenement district in large city. Husband went to work in a factory.
   C. Educational—Cannot read or write.
   D. Economic—Has been a fairly good housewife, according to tenement standards.

III. History of the Present Crisis.
   A. Physical—Has mysterious "shooting" pains in arms and legs. Bad headaches and insomnia. Is very constipated. Has frequent "tremors" which shake her all over. Complains of constant fatigue.
   B. Social—Has always been intensely religious. Has always observed all the Jewish customs and rites. Has worried because her husband has to work on Saturday. While her children were little she was too busy to worry much, but now that they are all grown up, and most of them married, she has time to think. And she sees that she is the only one who has "kept the faith." Her husband has no time for religious observances and her children have grown up without any respect for the religion of their fathers. She worries constantly about her family. She is very much shut off from them as they almost always talk English, which she, having lived in a Jewish quarter since coming to America,

has never learned. They translate some of their talk for her, but she feels that they are ashamed of her and think her old-fashioned. Her family has simply grown away from her and she no longer understands them; consequently she does the only thing she can—she worries.

C. Educational—Nothing.

D. Economic—No disturbance of importance as she now has comparatively little to do.

IV. Present Condition.

A. Physical.

Overweight. Diminished reflexes. Somewhat anæmic and exhausted from her numerous pregnancies.

No special defects.

B. Appearance and Behavior—Seems agitated. Occasionally cries and wrings her hands. Complains of her family. Appears to be very tired.

C. Intellectual Condition—General level seems about average.

Special functional disorders: thought is very much centered around her family cares and her religion.

D. Emotional Condition.

General Emotional Tone—Is depressed.

Special Emotional Trends—Seems dominated by worry and anxiety over family.

Emotional Conflicts—Is in constant conflict with an environment that she is powerless to change. All her religious principles are constantly being violated by the people she loves most. Is too vigorous to withdraw from the conflict and is unable to adjust.

V. Summary and Conclusion.

A. Summary—Overweight, insomnia, headaches, "pains," extreme constipation. Is worried and anxious; thoughts center around emotional preoccupation. Is permanently estranged from family through circumstances. Is an overreligious person in an unreligious family.

B. Conclusion—Neurasthenia.

Hysteria. The family history of the hysteric is not likely to be very different from that of the neurasthenic; however, the family may contain individuals who are excitable emotionally rather than repressed. Similarly the history of the individual will exhibit more of an excitable than a repressed personality, and a much less closely knit introspective personality. The hysteric is a person who overreacts to an emotional stimulus.

And she (it is more often a "she")[1] is likely to be a person who is somewhat extravagant in the expression of her feelings. In certain respects the individual is peculiarly childish and self-centered and, like a small child, very fond of attention. The investigator is likely to find a record of impulsive acts in moments of emotion, outbursts of temper, and sudden shifts from one mood to another. In contrast to the neurasthenic, the hysteric may have many friends and outside interests; the friendships are rather likely to be extravagant and somewhat temporary, however, and the interests shallow and selfish. The medical history frequently shows a certain amount of physical frailty or mild invalidism, though it often is difficult to determine how much of this is genuine and how much assumed, unintentionally perhaps, for the soliciting of sympathy. School work may be good, bad, or indifferent; there may be some signs of irresponsibility in adult life. The person may possess almost any degree of intelligence.

This person of hysterical make-up is known to everyone—a demonstrative, somewhat flighty, tense individual, more or less strained and unsatisfied emotionally. If this individual now develops hysteria she begins to show various physical symptoms, more or less bizarre according to her intelligence and the circumstances which have called them forth. There may be definite attacks, and these may be of a number of types. So there may be dizziness and fainting, or a kind of convulsive seizure—often very suggestive of epilepsy (see the first case following). Or there may be the development (as a result of such an attack or without any obvious cause) of certain peculiar physical symptoms. Contractures or paralyses of various kinds may appear; so one arm may be paralyzed. There may be areas of anæsthesia (or hyperæsthesia). The anæsthesia usually appears in distinct bands or areas—there are

[1] This is probably not an innate sex difference, but rather a product of the greater restraints put by society upon the life of the average girl and woman. It will be interesting to note whether, with the gradual freeing of women from sex limitations, their "nervous" difficulties will diminish.

the "stocking" and the "glove" anæsthesias in which the patient has no sensation in the areas usually covered by these garments. There are also sometimes hemianæsthesias; the patient is without sensation on one side of the body. A narrowing of the visual field is supposed to be a rather distinctive symptom of hysteria. It is rather easy to demonstrate, however, that these various conditions are not due to any organic lesion. Thus in the anæsthesias the areas involved do not coincide with the areas supplied by any nerve trunks; also the anæsthesias may disappear far too suddenly to have organic foundation. Or the symptoms may be more vague; there may be various "pains," apparently of a neuralgic nature. In some cases there may be very exact imitations of some disease as seen in another member of the family, or recurring attacks, apparently, of some minor physical illness previously experienced by the patient.

Naturally such a person is very puzzling. Treatment as if for physical disease may give no relief, or there may be a recovery with, before long, a whole new set of symptoms. And it gradually becomes evident that the symptoms are essentially a product of an emotional, not a physical, condition.

In general, apparently, the symptoms may be connected with an emotion in two ways (perhaps fundamentally the same). Either (a) the display of the physical symptoms serves to obtain attention for the patient, or some other desired end, and so gratify the patient's desire for attention and sympathy. Or (b) the symptoms are a residual of some intense suppressed emotional experience. The first type may be illustrated by the unattractive girl in a private school who had a crippled friend upon whom constant sympathetic attention was showered. The unattractive girl developed a hysterical lameness. The second type is exampled in one of the following case studies, in which a girl satisfied her longings for masculine attentions by writing letters to herself (in passionate language, signed with a man's name) with her left hand, and then developed a hysterical contracture of this hand. In both

cases there was an intense emotional dissatisfaction, and nothing very obvious which the girl could do to remedy the situation. In both cases also there was a decided sense of inferiority, with shame and repression of the emotions aroused.

It should be understood that these conditions are not a conscious faking which can be dealt with by brutally charging the individual with anything of that sort. Nevertheless, it must also be realized that hunger for sympathy and attention is at the back of the manifestations; so any display of such feelings toward the patient will tend rather to perpetuate the symptoms or to make the occurrence of another attack more likely. It should also be appreciated that although the hysterical temperament is often exceedingly irritating, it may be the product of emotional hardship or deprivations which might well be expected to lead to abnormal conditions even in an individual who started life with a normal nervous system. The individual is often bitterly chagrined and ashamed of her difficulties. And this intense feeling tends, of course, to a recurrence of the phenomena. The attitude that those having to do with a hysteric take toward her condition is thus exceedingly important; and it is vital that just the right attitude should be taken.

What, now, should be done in the treatment of the hysteric? It is evident that the treatment of isolated symptoms is often worse than useless. Evidently the treatment must go directly after the underlying causes. These causes are, in general, two in number. There is first of all an inadequately organized personality. If the person is sufficiently intelligent and mature it will probably be advisable to give insight by explaining sympathetically but without any sentimentality the real mechanism back of the symptoms. Following this explanation a period of reëducation must be entered upon; this should begin with an arrangement by which the person reports at intervals, especially when difficulties arise, to the sympathetic and understanding social worker or physician in charge of her case. The effort should be to guide the patient through emotional crises, develop a certain emotional hardihood, and train her to more effective methods of dealing with difficulties. The second

cause referred to above, is to be found in the environmental conditions. In all cases there should be an earnest attempt to so alter the environment that the emotional stress will be removed or lessened and the conflict therefore resolved. Friendships should be developed for the unattractive school girl and the lonesome clerk in the big city—the emotional problem should be solved so far as possible. It should be realized, however, that by the time a character has developed to the point where frank hysterical manifestations appear, it has developed so far in unhealthy modes of reaction that a full return to adequacy can hardly be expected; the best that can be done usually is to reëducate the individual to some degree, and place her in an environment that is relatively free from strain.

The best chances for a permanent alteration of the personality are found, of course, in those cases that are recognized in childhood. Again there is evidence of the importance of early training, and the great possibilities in the way of character building in the schools. The hysteric temperament usually shows itself at an early age. The school psychologist should become familiar with hysteric types of response among school children, so that these cases may be recognized early, and given the type of guidance of which they are particularly in need.

The following cases will make clearer the total picture.

Case No. 8

Name: Laura M. *Age*: 19. *Sex*: Female. *Birthplace*: Massachusetts. Single. *Sources of information*: girl's mother, employer, teacher, the girl herself.

I. History of the Family.
   A. Medical—Nothing of importance, except alcoholism in father.
   B. Social—Father alcoholic, frequently comes home drunk; is then rough and abusive. Otherwise is quiet and seems fond of his family. Besides the patient, three younger children.
   C. Educational—Parents had little schooling. Children all in school except patient.
   D. Economic—Father clerks in a store.

II. History of the Individual.
A. Medical—Nothing of importance—not very vigorous physically.
B. Social—Patient never was a very good mixer; rather quiet, sensitive, and retiring. Rarely goes out with friends more than once or twice in a month.
C. Educational—Grammar school education; school work average.
D. Economic—Clerk at ribbon counter of a dry goods store.

III. History of the Present Crisis.
A. Medical—One night father came home drunk, became angry and struck patient. The blow was only slight. However, patient fell, appeared to lose consciousness; there were a few slight convulsive movements. After a brief period the patient gradually came to, appeared to be in a somewhat dazed condition. Father much alarmed and sobered by the episode. Patient has recently had several such attacks at times of crises in the family, usually when father was intoxicated.
B. Social—The patient does not get along well with father; much disturbed by his drinking. Says she cannot ask friends to the house because he may come in and disgrace her.
C. Educational—Nothing.
D. Economic—Little if any affected.

IV. Present Condition.
A. Physical.
General health fairly good, but not vigorous.
Special defects—None.
B. Appearance and Behavior—Neatly dressed, rather bashful and reticent, does not talk readily. Appears easily upset emotionally.
C. Intellectual Condition.
General Level—Has an I.Q. of 101. Appears normally bright and interested in things around her.
Special Functional Disorders—Judgment is somewhat abnormal in that she feels so strongly about the unfitness of her home. Memory, normal, except for the "fainting spells" above mentioned. Association is somewhat erratic, in that she associates everything with her home conditions. Intake—some contraction of the visual field.
D. Emotional Condition.
General Emotional Tone—Easily depressed or excited. Her mother says the girl is frequently found in her room crying, but can give no definite reason for it; sometimes the girl amuses her family with funny stories, illustrates dance steps, and generally "acts crazy."

Special Emotional Trends—Is afraid of her father; seems dominated by this fear. Seems to have no emotional hardihood.

Emotional Conflict—Father's drinking causes an unfortunate home condition, which makes this girl ashamed of her home and afraid to go there. She says can she cannot invite anyone home, cannot have friends because they will find out about her father. Nevertheless she seems distinctly fond of her father.

V. Summary and Conclusions.
   A. Summary—Father alcoholic, and rough and abusive when drunk. Occasional "fainting attacks" in times of emotional crisis, after such an attack, following a slight blow from the father, had had a sobering effect on him. Average intelligence—emotionally somewhat unstable—overemotional.
   B. Conclusion—hysteria.[1]

Case No. 9

Name: Dorothy R. *Age*: 21. *Sex*: Female. *Birthplace*: Massachusetts. Single. *Sources of information*: girl, grandmother, brother, Y. W. C. A. matron, physician, employers.

I. History of the Family.
   A. Medical—Normal.
   B. Social—Married sister is reported as "queer" though nothing specific could be determined. No two members of the family live together or are on good terms with each other. Little known of parents, who died while the children were young. The three children were brought up by grandmother, who was well-meaning enough but had no control over them. Admits that she could not discipline them, that they paid no attention to what she said.
   C. Educational—Only grade school education for any member of family.
   D. Economic—One sister married, one works in a candy factory, brother a shipping clerk.

II. History of the Individual.
   A. Medical—Always sickly and "ailing." Had convulsions when small.
   B. Social—Always did as she pleased. Had a very bad temper with terrific outbursts, when she would scream and throw herself about, over trifles. Has few interests. Has never been popular with boys, although she has always been

[1] In this case a complete cure was obtained by sending the girl to the country for a few weeks and then keeping her away from her father. She is now married, happy, and in good health, and has no attacks.

"crazy" about them, according to the testimony of grandmother and brother. Lived by herself until recently when she was suddenly moved by an evangelist to "reform." Obtained room at Y. W. C. A. where she has been conspicuous by having attacks of weeping and wailing over her former transgressions. Matron says she is is not content unless people are focusing their attention on her.

C. Educational—Finished grammar school.

D. Economic—Is now clerk in a store. Has changed position four times in past year.

III. History of the Present Crisis.

A. Medical—Attacks of weeping and general "hysterical" outbursts.

B. Social—Insists that there is a man annoying her. Shows letters from him written in most passionate language. Shows other letters from a girl friend asking her to return to the "old life," and receive the man as her lover. Has refused to leave the Y. W. C. A. unless accompanied by someone. One evening she received from the man a threatening letter which frightened her; she immediately had an attack of screaming during which she appeared to lose consciousness. Upon recovering, she declared her left arm was numb and she could not move it. Was sent to a "mental ward" in a hospital by the Y. W. C. A. authorities. Diagnosis was finally much aided by a confession from the girl that the lover was imaginary, and that the letters he was supposed to have written she had written herself, in a disguised handwriting, using her *left* hand.

C. Educational—Nothing.

D. Economic—Has been very irregular recently as she would not leave room unless accompanied.

IV. Present Condition.

A. Physical.

General Health—Girl appears frail and white, weak pulse. Is diarrheic. Cannot move left arm although the arm is entirely uninjured.

Special Defects—Paralysis of arm.

B. Appearance and Behavior—Appears distraught. Is noisy; has outbursts of laughter or tears. Talks almost continuously about all kinds of things. Walks about office. Clothes of a cheap sort, but showy.

C. Intellectual Condition.

General Level—I.Q. of 93. Did well on tests, but seemed uninterested; could probably score higher if she were not so distracted.

Special Functional Disorders—Ideas center about imaginary

episodes with men. Attention is somewhat erratic; talks of her troubles readily, but soon digresses—is "flighty." Memory, association appear at time of examination to be fairly normal; intake normal except for anæsthesia in left arm.

D. Emotional Condition.
General Emotional Tone—Overemotionality, easily excited. Overacts to any emotional stimulus with violent emotional discharge.
Special Emotional Trends—Seems unduly anxious.
Emotional Conflicts—After this girl had made her confession the conflict, which was suspected earlier, became evident. She has always wanted lovers, but had never been sufficiently attractive; she was also held back for fear of disease or pregnancy. Her supposed immorality was wholly of an autoerotic nature, the result of daydreaming and imaginings. She felt very keenly her lack of attention from men, and invented a situation in which she appeared as the center of masculine attention. The letters were a part of her dramatizing, to give it the appearance of truth. She was trying to effect a compromise between her desires and her environment; that the compromise was not adequate is evidenced by her emotional upsets.

V. Summary and Conclusion.
A. Summary—Undisciplined childhood; highly emotional; physically frail. Few friends during adolescence but marked sex interest. Recent emotional climax, imaginary experiences of a sexual nature, involving much attention-getting from those about her; functional paralysis of arm.
B. Conclusion—Hysteria.

Psychasthenia. There is a third, less common, type of emotional maladjustment in which the emotional stress is expressed in a group of peculiar phenomena which may be called *psychasthenic.* Individuals suffering from this type of disorder are usually found to have neuropathic heredities. The personal history is very similar to that of other neurotics. There is usually no definite episodic crisis, as in hysteria, but rather a gradual development of a morbid condition as in neurasthenia. There are practically no physical symptoms, except as emotional strain may bring about general conditions of insomnia, loss of appetite, and so forth.

The disease consists essentially in the recurrence of uncon-

trollable ideas and impulses which force themselves into the patient's mind, persistently demand attention, and are not to be controlled through the patient's own will-power. These ideas are obsessions or phobias of various kinds—ideas which have escaped from the control of the individual's will and now lead a tormenting existence independent of his wishes. The traditional pyromaniac and kleptomaniac are dramatic examples of persons with such impulsive ideas. The condition should be more or less familiar to everyone, as most people have had minor phobias, or bits of superstition (especially in childhood) from which they were unable to escape. The psychasthenic exhibits this sort of phenomena to a marked and pathological degree. Moreover, in most cases of this sort, there are elements of emotional maladjustment in the background which appear to have a very important relationship to these peculiar phobias and obsessions—appear, in fact, to give them their force and the energy that continues their existence. Sometimes the emotional difficulty appears to be hardly explicit, but rather the result of long-continued bad habits of thought and emotional maladjustment. More often, some fairly specific emotional episode appears to be at the back of the impulsive ideas or phobias with which a patient may be troubled at a particular time. In studying the case one usually has the feeling, nevertheless, that the trouble is founded in a more fundamental weakness—that such difficulties are rather inevitable and likely to be more or less chronic.

The type can best be made plain by the two case-studies following. It must not be supposed that the symptoms are always so obviously motivated as in these two cases. Pyromanias usually show no such definite psychogenesis. But such emotional backgrounds are likely to be found; something more than the impulsive act or phobia is surely to be looked for. In the group of the psychasthenics are to be included those persons with chronic doubts and scruples—usually of a religious nature—dipsomaniacs, kleptomaniacs, the people with peculiar and extreme fears, as of closed places, open spaces,

morbid fear of blushing, and other less common types of phobia. The feature that all these people have in common is the peculiar power that some particular idea has over them; they cannot refuse to attend to it, nor can they in any way control it. The ideas may be different enough, but the feeling of the afflicted person toward them is the same.

It may be said at once that the hope for complete recovery appears to be rather less for this type of difficulty than for the other two types of neurotic condition already mentioned. The particular fixed idea troubling at a particular time may be eliminated. But other impulsions or phobias are likely to take its place.

CASE No. 10

Name: William F. *Age*: 19. *Sex*: Male. *Birthplace*: Massachusetts. Single. *Sources of information*: boy, father and mother, brother, school principal, priests in the training school where the patient had been.

I. History of the Family.
   A. Medical—Normal.
   B. Social—Family rather intensely religious; very conventional.
   C. Educational—Grammar school education, one brother in high school.
   D. Economic—Father a small tradesman.

II. History of the Individual.
   A. Medical—Normal.
   B. Social—Had been something of a recluse. No close friends could be found by the social worker. Had entered training for the priesthood at eighteen. Since that time had lived a rather strenuous and solitary life in a monastery.
   C. Educational—Was in high school when he left to enter priesthood. Was in school at the monastery. Had always been hard working but not especially bright.
   D. Economic—None.

III. History of the Present Crisis.
   A. Medical—Has been unable to sleep because of worries.
   B. Social—When the boy entered the priesthood he had the utmost respect for the priests,—in fact, he practically worshiped them and allowed himself to be guided by them in all things. Strove to imitate them exactly. Recently, he had found out that one of the priests was having illicit relations with a woman. He thought some of the other

priests also guilty. Is now torn between his lifelong desire to become a priest and these new revelations that have disgusted him. Has returned home and seems to be undergoing something of an emotional conflict. Has recently (within the last few days and before leaving the monastery) been frequently seized with an impulse to undress himself. When this compulsion comes upon him he starts removing his clothing wherever he may be. He spends almost the entire morning getting dressed as the impulse to undress is particularly strong at this time. Has appeared somewhat dazed and confused at times.

C. Educational—Has been obliged to leave the monastery because of his impulsive idea. The priests tried disciplining him and finally sent him home!

D. Economic—Nothing.

IV. Present Condition.

A. Physical.

Rather slight build. A bit underdeveloped. Insomnia. Constipation. Has a positive Wassermann though no one else in the family has.

No special defects.

B. Appearance and Behavior—A bit restless and apprehensive sometimes—otherwise rather listless. Sits languidly in chair most of time during interviews, but occasionally glances over shoulder or turns and looks behind him; these acts are followed by a few minutes of restlessness and squirming and then the listlessness reappears and lasts for 10-15 minutes. When his obsession comes upon him he jumps up, runs around the room, talks excitedly, and starts ripping off his clothes in great haste.

C. Intellectual Condition.

General Level—Was almost impossible to test, because his attention was so hard to hold. Earned a rather low I.Q. but the examiner was sure the boy was well within the normal group. (Later testing confirmed this supposition.)

Special Functional Disorders—Intellectual life decidedly disorganized by the emotional stress. Attention and association erratic. Memory apparently normal but examination difficult.

D. Emotional Condition.

General Emotional Trend—Seems rather apathetic, except when his compulsive idea seems to force him into great excitement and activity.

Special Emotional Trends—Seems dominated by anxiety and worry.

Emotional Conflict—The conflict appears rather obvious. He had been living in a world removed from the ordinary

strains of life. His sheltered childhood and equally sheltered monastery existence had not prepared him for the revelation of what he considered unforgivable sins in one or more of the priests. His reaction has evidently involved a sex episode which has made an intense impression upon him.

V. Summary and Conclusion.
  A. Summary—Secluded and emotionally isolated childhood and adolescence. Recent emotional shock and also sexual experience in extreme conflict with all preformed emotional attitudes and principles. Impulsive act obviously related in some way to this experience; marked emotional apprehensiveness; intellectual life largely disorganized by the emotional stress. Insomnia, constipation—syphilis.
  B. Conclusion—Psychasthenia.

Case No. 11

Name: Minerva J. *Age*: 35. *Sex*: Female. *Birthplace*: Kentucky. Single. *Sources of information*: patient, matron at orphanage, and two trusted employees there, correspondence with mission school.

I. History of the Family.
  A. Medical—Nothing known.
  B. Social—Family were "mountain whites" of Kentucky.
  C. Educational—Illiterate.
  D. Economic—Were farmers. The family was always poverty stricken.

II. History of the Individual.
  A. Medical—Has always been well.
  B. Social—Attended a mission school when about sixteen. Was there for some years. The people became interested in her and trained her to be a housekeeper. After a while they sent her North to Boston as an assistant housekeeper in an orphanage. She did not marry, as practically all the "mountain whites" do.
  C. Educational—Finished grammar school and received a very thorough domestic training.
  D. Economic—Was doing her work as housekeeper satisfactorily.

III. History of the Present Crisis.
  A. Medical—None obtainable.
  B. Social—Has had some difficulty in adjusting to her new environment. Has no funds. Does not get along well with others in the institution. Says that people in Boston think she is just "poor white trash." Has recently been stealing baby-clothes when they came back from the institution laundry. The missing garments were found in a pile in her

closet. At first, she denied having taken them, saying that some one else must have put them there, that the charge of theft is a plot to get rid of her. Finally, she confessed that she took them, but that *she couldn't help it*. She did nothing with them, never sold them or made any use of them.

C. Educational—Nothing.

D. Economic—Has been doing her work about as usual.

IV. Present Condition.

A. Physical.

General Health—Good general health. Rather underweight.

Special Defects—No special defects.

B. Appearance and Behavior—Quiet, talks little, expression set, sits stiffly in chair, tense. Has a suspicious, antagonistic attitude. Dressed neatly but unattractively. Is thin and angular; has high cheek bones and a thin sharp face.

C. Intellectual Condition.

General Level—Impossible to determine, but seems fair. Lack of coöperation and suspicion as to what the examiner was after made the examination practically worthless.

Special Functional Disorders—None, unless her antagonism and suspicion be counted; however, this attitude is probably a natural result of being in an environment that one does not understand. Probably a defense reaction.

D. Emotional Condition.

General Emotional Tone—Shows little emotion; seems apathetic.

Special Emotional Trends—None observable.

Emotional Conflict—Questioning elicits nothing, but there is suspicion that the selection of baby clothes as an object to be stolen indicates a desire for marriage and children. No statements can be obtained, however. She meets every attempt at questioning with antagonism. Her defensive attitude gives the impression that she has something to conceal. A conflict is suspected between what might be called her "social heredity" or her ideas of social relationships gained from her early life among the mountain whites, and the environment in which she has found herself—an environment singularly devoid of possibilities for marriage. Her case suggests that complete uprooting and transplanting of individuals, after maturity, is likely to lead to conflicts with the new and little understood environment.

V. Summary and Conclusion.

A. Summary—Inferior stock; poor early environment, somewhat paranoid attitude, compulsive act (theft of baby clothes), probable emotional conflict.

B. Conclusion—Psychasthenia.

So much then for the psychoneuroses. The writers have preferred to present them as three types of reaction (appearing in persons either constitutionally predisposed or susceptible because of settled bad habits as regards emotional control and expression) to situations of emotional conflict and stress. In the neurasthenic the emotional difficulty continually distracts and there is a condition, primarily, of emotional preoccupation and of emotional and nervous exhaustion. In the hysteric we have the same emotional conflicts expressed in emotional episodes and their residuals. In the psychasthenic, emotional difficulty involves itself in a peculiar degree with some special act or thought, being transferred to this act or thought from the original cause. In all three conditions there is an emotional difficulty with inadequate adjustment.

The Emotionally Unstable

In the difficulties just considered are exhibited three types of reaction to emotional conflict or stress—reactions which are essentially evidences of inability to cope with an emotional difficulty, and so reactions which most readily appear in individuals constitutionally somewhat inadequate. The individuals to be included in the present category are even more to be thought of as exhibiting constitutional anomalies of character. They are also distinguished as reacting peculiarly to emotional situations. The concept is particularly likely to be abused since the conditions which it is intended to include here are not, strictly speaking, conditions of disease, but rather character anomalies. And there are no "symptoms," in the ordinary understanding of that word—there are only difficulties of social adjustment so striking and unrationalizable that one feels that there must be an underlying pathological condition. Once given the concept, then, there is a temptation toward disposing of all cases showing social maladjustments by putting them in this group—if the cases cannot be still more easily disposed of as feeble-minded.

The "psychopathic personalities" (the group which the

writers have sought to characterize as the group of the "emotionally unstable") thus show not a disease, but a character anomaly. They may thus be expected to exhibit their peculiarities from childhood. From early childhood they have displayed a lack of emotional control (or occasionally a peculiar baffling lack of emotion), a perversity, an emotional morbidness, which has been so extreme as to lead one to feel that only a character containing definite pathological elements could exhibit such extravagantly irrational and ill-judged behavior.

It is evident, that under such circumstances, diagnosis of a case as belonging or not belonging to this group will depend upon one's standard as to morbid or irrational conduct, and the variety of one's experience in leading him to realize that conduct may be rationalized in many ways and that reaction to emotional situations may, in anyone, take a form superficially irrelevant. In diagnosis the rule should be that a "psychopathic personality" must exhibit (a) marked emotional instability (or perversity) and (b) striking lack of judgment, from childhood, *without* the presence of any emotional situation which could be understood as an irritant at the back of such a temperament. The most important precaution, the writers feel, is to be sure that the case is to be considered pathological at all. The usual psychiatry is more taken up with the distinguishing of the "unstable" case from the hysteric, the paranoid, the subnormal, and the epileptic. All these other more closely characterized conditions should be considered first, particularly because treatment of these conditions is much more clearly defined and more likely to result beneficially and because the progressive nature of these other conditions makes treatment more imperative. The general problem of differential diagnosis will be returned to later.

The study of the family history of the unstable individual is very likely to reveal the presence of nervous and mental disease or defect, sporadically, among the members of the family. One or the other of the parents is likely to be similar in character to the patient; alcoholism, sexual debauchery, criminality, quarrelsomeness, and excitability are usually prominent characteristics of the family. The patient may be illegitimate.

The family is usually of the strikingly disorderly sort, a chronic source of trouble in a community.

Just so is the character of the patient! He has probably, since infancy, been willful, perverse, obstinate, of uncontrollable temper, impossible of discipline in home or school, a terror among other children—guilty, perhaps, of wanton cruelty. Capacity for school-work appears good, but attendance is usually too irregular, and interest too erratic, for any considerable progress.

Sex experiences and excesses of all sorts begin early. The case is usually known to the police. The individual is quite capable of earning a living. But he seldom stays long at one job; he either quarrels with the boss or other workmen, goes on a "spree" or—simply decides that he would like to try another place.

Such cases are—almost by definition—chronically in trouble. When seen by the personnel manager, by the court official, or by a social worker, the case is usually found to be well developed physically, perhaps unusually vigorous, unless the diseases brought on by excesses have seriously impaired the physical condition. The individual is very likely to be flippant, rather insolent and reckless in manner, noisy and free-spoken. Dress is usually either slovenly or "flashy." There may be a considerable display of superficial emotion; the person weeps, laughs, sneers, bluffs, bullies, and acts frightened—all in a few minutes. He usually talks readily, if carefully handled at first, and then gives a free-flowing account, characterized by superficial and cheap emotion and showing frequent instances of faulty judgment. There is either much lip-service to the conventional code of morals, or a curiously baffling complete lack of appreciation of the usual rules of conduct.

Further details are hardly needed to characterize the type. It also need hardly be said that such characters are exceedingly hard to work with. The problem in treatment is not to cure a condition, but to change a personality constitutionally intractable, emotionally irritable and not to be reasoned with.

Evidently, very little can usually be done. One can fall back on the much-abused change-of-environment remedy; but usually one will do no more than disturb one more set of people without doing the patient any good. Some degree of re-education is possible. A young boy may be helped by a year or two in a military school or the man by enlistment in the navy; the discipline is sometimes the individual's salvation. Quite as often, however, the discipline seems simply to involve him in more severe penalties. Institutional care seems often the only solution. Striking cases may occasionally be committed to a hospital for the insane or a school for the feeble-minded. The group is too ill-defined to receive specific legal recognition as a type deserving commitment, and is, perhaps, the most irritatingly troublesome of all mental types.

It should be added, however, that in the hard school of experience such cases do appear, after a while, to learn; and as they progress into middle age they are less frequently heard from. Sometimes there is a suggestion in this sobering off that the difficulty may have been primarily a physiological affair —presumably connected with the ductless glands—which was accentuated (if not developed) during puberty and adolescence but which disappeared with physical maturity. Some cases suggest such an explanation very markedly; there are nervous symptoms, perhaps something as explicit as chorea. Or, there is a suggestion that the case may be suffering from chronic mania.

One remaining type of psychopath remains to be mentioned briefly—the group of the sexually psychopathic. These cases should be considered separately from the type just described, since sex anomalies usually exist in persons not otherwise psychopathic. But true sexual psychopaths are to be considered similarly constitutionally peculiar. Marked cases of homosexuality (the desire of a person for sex relations with another of his or her own sex) are likely to suggest a physiological origin in the failure of normal development of the sex organs. It is very necessary to keep in mind, however, that not all "abnormal" sex practices are abnormal. Persons in-

dulging in homosexual practices in circumstances where heterosexual relations are not possible—as in the navy, in girls' or boys' boarding schools or in prisons—are surely not to be classed with those choosing homosexual relations from preference. Most adolescent boys and girls when living in groups by themselves have some homosexual desires; the sex emotion is strong at this age and, since persons of the opposite sex are not in evidence, it is transferred to some one of the same sex. In fact, whenever the sexes are isolated from each other, the appearance of homosexual practices is to be more or less expected, even though the isolation is comparatively nominal. A certain well-known eastern university is notorious in this respect.

It should be understood, then, that a case is to be considered homosexual only when there is a distinct preference for sex contact with another person of the same sex. It should be added, also (a fact that seems not generally recognized), that homosexuals are fairly common—especially among men—that there are male prostitutes, and that most homosexual cases are never discovered or even suspected.

It should be added that sex peculiarities may sometimes be at the bottom of marital and family difficulties. One or the other—either the husband or the wife—may be excessively erotic or frigid, or there may be a perversion of some sort. And finally, it should be pointed out, that to some persons cruelty gives sex pleasure. Wife or child beating is sometimes thus explained.

The following two cases will make clearer the concept of the emotionally unstable. The second case is perhaps the better example of the type. The first is, however, typical of a large group of sex cases, and so well worth study.

Case No. 12

Name: Violet M. *Age*: 17. *Sex*: Female. *Birthplace*: Florida. Single. *Sources of information*: girl, father, mother, employers, school principal.

I. History of the Family.
  A. Medical—Normal.
  B. Social—Girl is an illegitimate child.
  C. Educational—Family has common school education.
  D. Economic—Father a carpenter.

II. History of the Individual.
A. Medical—Normal.
B. Social—Has always been hard to control. Would not mind when spoken to. Has outbursts of temper over nothing, but recovers from these almost instantly. Is flighty and unreliable. Cannot be trusted to handle money as she spends it on trifles; recently started out to buy some shoes and came home with a fur cape she had contracted to buy "on time." Frequently lies about her expenditures. Sometimes seems very emotional—sometimes reserved and cold. Gets excited easily and will burst into tears at anything sad or pitiful. Is sometimes depressed. Cries "perfect rivers" at the "movies" and apparently enjoys doing it. Has never been able to get on with her family or any one else. Makes friends easily, but loses them more easily. Is utterly selfish. Will not help with the housework. Is willing the family should go without things if she can have what she wants. Every three or four months she "disappears" for a few days and refuses to tell where she goes although she admits being a prostitute during these periods. Was once pregnant, but went away and came back "cured." Tries to lead a "high life." If talked to about her behavior weeps, promises never to do such things again, and promptly does them when opportunity next affords.
C. Educational—Entered high school. Then left to go to work.
D. Economic—Has been working in clerical positions but never holds any position more than a month or so. Has had 15 different jobs.

III. History of the Present Crisis.
A. Medical—Committed abortion, which horrified her family.
B. Social—Has been disappearing off and on for a couple of years, apparently for a period of excitement and sex indulgence. Family cannot understand her and wish her examined.
C. Educational—Nothing.
D. Economic—Economically entirely irresponsible.

IV. Present Condition.
A. Physical.
Slightly undernourished.
No special defects.
B. Appearance and Behavior—Restless and boisterous. Fidgets and moves about. Sings snatches of songs. Weeps when reasoned with. Shows occasional flashes of temper. Uses profanity freely.
C. Intellectual Condition.
General Level—I.Q. of 85. Low normal.

Special Functional Disorders—Is lacking in judgment and common sense. Is flighty. Attention poor; skips from one thing to another without any apparent control. Memory, association and intake seem normal.

D. Emotional Condition.
General Emotional Tone—Excitable, but all emotions of a very superficial nature.
Special Emotional Trends—None.
Emotional Conflict—No evidence of any obtained. Apparently Violet does anything she wants to do, so has little opportunity for developing conflicts.

V. Summary and Conclusion.
A. Summary—An illegitimate child. Has committed abortion. Intermittent prostitute. Utterly irresponsible; immoral, cannot get along with any one. Since childhood great emotional variability, shallowness, lack of emotional control.
B. Conclusion—Emotionally unstable (psychopathic personality).

CASE No. 13

Name: Durval C. *Age*: 17. *Sex*: Male. *Birthplace*: Illinois. Single. *Sources of information*: boy, mother, uncle, older brother, school officials.

I. History of the Family.
A. Medical—Father died of pneumonia when boy was six years old. One paternal cousin insane.
B. Social—Family rather prominent in the small city in which they lived.
C. Educational—Father was college graduate; mother graduate of normal school.
D. Economic—Family distinctly well to do; two uncles wealthy.

II. History of the Individual.
A. Medical—Has always been well, if anything overactive.
B. Social—Has shown signs of peculiarity and emotional instability since early childhood. As a small child had "tantrums" when he could not have his own way; would sulk in his room at other times, hardly leaving his room for several days. Was completely unmanageable. When seven years old began staying out nights. Later would steal from his mother and go on trips. Stole from an aunt when on a visit to her, although he had plenty of money at the time, and made no use of what he had stolen. As a child seemed to take a delight in teasing animals. Is believed to have indulged in various sex practices as a child, though never actually detected in anything of that sort. In high school notorious for his escapades. Exceedingly disagreeable, even

insulting to the teachers. Had learned various "Jiu-Jitsu" wrestling tricks, and injured several boys by suddenly using these tricks in supposedly good natured wrestling matches. Threatened another boy with a large clasp knife—finally cut him severely on the hand. Has had various sex episodes.

C. Educational—Has always done well in school; does little work, but learns very easily and is very clever about making a good appearance so far as his school work is concerned—an excellent "bluffer."

D. Economic—Clerked in a haberdashery one summer, but stole from his employer; the family made good the loss. Took not only money but also neckties and other articles which caught his fancy. Worked in a summer hotel another summer; did not remain through the season but the reason was not known.

III. History of the Present Crisis.

A. Medical—Has gonorrhea.

B. Social and Educational—Was expelled from the local high

& school. Was then sent to a private preparatory school; was

C. expelled from this school. One of the uncles then sent the boy to a military academy well known for its strict discipline. Within two months he was returned from this school after various experiences in the red light district of a nearby city.

D. Economic—The usual pilfering had continued but was now somewhat in the background.

IV. Present Condition.

A. Physical Condition.

Rather slight but well built boy of 17; appears somewhat more mature physically than his age would suggest. Has gonorrhea. No special defects.

B. Appearance and Behavior.

Very well dressed—in good taste, but somewhat in the extreme of fashion. Talks readily, expresses himself well. Evidently intelligent, and from a home of culture. Manners very agreeable; has a pleasant smile. Absolutely calm and at his ease. Has very little to say about his delinquencies. Attitude seems to be, "Well, what are you going to do next?"

C. Intellectual Condition.

General Level—Passes all tests but one on the Stanford Binet; evidently decidedly intelligent and well informed. No evidence of special defects.

D. Emotional Condition.

Very calm, appears rather indifferent, though alert. No special emotional trend. There does appear to be, under his

smooth manners, a peculiarly disagreeable callousness and cynicism. No evidence of conflict, certainly none of repression.

V. Summary and Conclusions.
   A. Summary—Extraordinarily persistent and unintelligible delinquency and intractableness, since early childhood. Heartless, cruel, without affection for any one. Sex delinquency especially prominent. Has gonorrhea. Comes from an excellent home. Unusually intelligent, well informed, and well mannered. Relatives have apparently tried everything in an effort to control him.
   B. Conclusion—Psychopathic personality, sex element prominent.

The Mentally Peculiar

One last group of the borderland cases remains to be presented; this group is made up of the "eccentric" (perhaps better, the "egocentric")—such people as the cranks, the fanatics, the reformers, the chronically unsuccessful inventors, and all the people with queer ideas and no sensible judgment about them. As will be seen later, such conditions may develop to the point where the queer ideas are so manifestly false as to be considered definite delusions, and there is a frank psychosis—paranoia. However, here, as elsewhere, one may expect every possible condition from the most hard-headed common-sense of the successful business man to a solemn conviction that one is God Almighty Himself.

It should also be pointed out that only certain special forms of delusion are likely to bring one into such conflict with society as leads to careful study and diagnosis. If a person develops the delusion that he is being swindled out of a patent (for what is really an impossible invention) by high government officials, and makes threats against them, he is very certain to receive early recognition as mentally deranged. But another person, having an invention equally impossible, having similar difficulties with the patent office and developing similar ideas with regard to the duplicity of the officials, may settle down to a systematic "grouch" against the patent office and vent his feelings through legal proceedings. A third case may be similar in all respects to the first case mentioned except in this minor circumstance (from a psychiatric point of view),

that his attitude in attempted interviews with officials is not threatening, but pompous or whining; unless exceedingly persistent, the man is simply turned away as a crank. Another case still may show his eccentricity in ideas quite as fantastic, but his bent may be toward wild schemes of reform or peculiar religious convictions. And again, the person is simply recognized among acquaintances as a harmless crank. The dangerous paranoiacs, the chronic "grouch" with paranoid ideas, the "crank," and the reformer thus all are essentially alike in being dominated by ideas which are incongruous with reality. The first individual is readily recognized as "insane"; the other three are hardly less mentally deranged, but are usually not considered as being in essentially the same class—they are merely regarded as nuisances.

In general it may be said that the various forms of delusionary psychosis have their counterparts in less overt conditions, not clearly psychotic but surely requiring a designation distinguishing them from the "normal" group of individuals. This group of the "mentally peculiar" is thus distinctly heterogeneous; and it is by no means small. To list from the acquaintance of the writers: there was a young man who agitated for a law requiring that the medical examination and treatment of women be by women physicians only; there was the tender-hearted S. P. C. A. member who agitated against the use of "Tanglefoot" because it was cruel to the flies; there was a Methodist deacon who stalked up the aisle, in the middle of a service, to remove flowers that were shaped into the form of a cross, because such a symbol savored of "papistry." The anti-vivisectionists, the anti-vaccinationists, are presumably for the most part to be included in this group. Fantastic religious sects have an especial appeal to such individuals. There are, besides, "crank" inventors, authors, and the paranoid group of those always suffering from some more or less imagined wrong. Of course not all reformers, injudicious promoters, mediocre authors, and chronic querulists are mental cases. But many of them are. Perhaps, as with the previous group, one might say that only those cases are to be considered pathological that cannot be explained any other

way. Such "impossible" individuals usually show a case study much as follows:

There is likely to be, in the history of the family, peculiarity suggestive of the kind of idiosyncrasy appearing in the patient. In fact, the family is likely to have a reputation as "odd," and may be made up either of visionary ne'er-do-wells or of very close-fisted individuals of an unpleasant, harsh, and uncompromising disposition.

The individual grows up in an environment thus conditioned. During his childhood he is known by other children as headstrong, egotistical, and opinionated; or he may be dreamy and, even in childhood, recognized as impractical and visionary. In either case, relations with other people are not free and natural. The individual is either in conflict with that total mass of attitudes and interests that constitute a community, or else is largely out of touch with his community. There is, of course, an exacerbation of all this at adolescence. And the final result is a self-centered, narrow-minded man who indulges his prejudices to the extent of self-deception, or a stubborn and impractical personality so out of touch with the common-sense facts of things that he has been able to develop some fantastical set of ideas without any notion of their fantasticalness.

The present crisis is usually somewhat accidental as far as the course of the difficulty is concerned. Some action happens to involve the patient with the police, or precipitate a financial crisis which may have been more or less imminent for some time and which sends the patient or his family to a social agency. In this crisis, the individual's idiosyncrasies and inadequacy stand out in vivid outline against the real conditions that surround him. The impossible nature of his ideas is perfectly evident to everyone except himself. The crisis sometimes comes about in connection with the individual's work; there may be trouble with his employer, or he may manifest a stubborn cantankerousness among his friends or business associates. Economic efficiency is usually good, except as interfered with by irrelevant interest in queer hobbies. Sometimes

family relationships become intolerable because of constant criticism and bickerings.

The study of the present condition usually reveals little not implied in the history. Physically there is nothing of definite importance. In his conversation the patient reveals himself as rather emotional and tempery, completely self-centered and stubborn, intolerant of any one's opinion but his own, incapable of hearing criticism, eager to condemn others, quick to take offense and become suspicious, closed to arguments, unable to reason about his convictions and—above all—with absolutely no realization of his mental condition. The individual's appearance and behavior are likely to be stiff and pompous, revealing an exaggerated opinion of himself and a total lack of modifying social contacts.

Evidently, as with the unstable cases, the prognosis is poor and there is little that one can do in the way of treatment. The difficulty is constitutional, or is rooted in the early beliefs and ideas of childhood in such a way that a change, after years of maturing, is largely impossible, as it would involve a remolding of the entire personality. Treatment must, rather, consist in making allowances for the peculiar disposition, and in arranging non-irritating circumstances so that as little harm as may be will come about. Almost by definition, the case cannot be reasoned with; thus he cannot be reëducated as can the neurasthenic or hysteric. He is a chronic problem.

That the type of character behind this sort of difficulty may be more understandable to the reader, the writers offer the following example:

Case No. 14

Name: John R. *Age*: 51. *Sex*: Male. Born in Vermont. Married. *Sources of information*: wife, daughter, a near neighbor, a deacon.

I. The History of the Family.
   A. Medical—Negative except that both wife and daughter are distinctly neurotic.
   B. Social—Both wife and daughter "poor mixers," seclusive and odd, daughter very self-centered and queer.

C. Educational—Daughter college graduate.
D. Economic—Father kept a store.

II. History of the Individual.
A. Medical—Nothing unusual.
B. Social—Man is a minister. He has lost one parish after another because of his religious ideas. People like him fairly well, except for his sermons. He insists upon preaching in such a way as to antagonize his congregation. He did what he called "preaching the noblest elements of *all* religions." His listeners would receive a mystical Buddhistic sermon one Sunday, an equally impractical "new-thought" sermon the next, followed by a discourse on the virtues of paganism, or a few remarks on the supreme bliss of free love! His congregations were composed largely of ordinary working people who "couldn't stand" his sermons. His ideas were exceedingly radical on all subjects, but he never *did* anything unconventional in his life. Finally he was "fired" for the eighth time in seven years and could not find another vacancy. He "supplied" for a Sunday once in a while after that, but was seldom asked to supply twice for the same congregation. The man seemed to have no feeling for the "fitness" of a sermon to his audience; he was wrapped up in his own ideas to the exclusion of everything and everybody else. Was very disagreeable when any one attempted to argue with him.
C. Educational—Theological school and college education.
D. Clergyman—Has been unable to hold a parish because of radical ideas and lives on wife's money.

III. Present Crisis—None. (The man's wife happens to have some money, and he writes articles for almost every radical journal that will publish his stuff.)

IV. Present Condition.
A. Physical Condition.
General—Health seems good.
Special Defects—None, except that he sometimes affects a lisp.
B. Appearance and Behavior—Talks freely and fluently, with a rather pompous air. Is inclined to be aggressive. Strikes poses and laughs loudly at his own jokes. Always tries to say startling things for the commotion they cause, making him a center of attention and interest. Has a stiff manner of holding himself.
C. Intellectual Condition.
General Level—Seems considerably above the average.
Special Functional Disorders—Judgment shows over centralization of all ideas around his intellectual radicalism, and

the importance of his own notions. Attention is excellent for whatever interests him, but quickly wearies if talk is uninteresting. Memory, normal. Association is normal, except that his special ideas are frequently dragged in. Intake normal.

D. Emotional Condition.
General Emotional Tone—Somewhat over-excitable.
Special Emotional Trends—Is absolutely self-centered.
Emotional Conflicts—No evidence of any. In fact, one conspicuous thing about this man is that he seems to have no regrets or other feelings about his failures.

V. Summary and Conclusion.

A. Summary—Egocentricity and lack of practical judgment. Great emotional self-satisfaction. Patronizing and conceited. Tries to achieve prominence at any social gathering. Loves publicity. Is very controversial. Generally disliked. Affected manner.

B. Conclusion—Mentally queer.

So much, then, for the "borderland" conditions—the "emotionally maladjusted," the "emotionally unstable," and the "mentally queer." It should be clear by now that all these cases have much in common besides the mere fact of their intermediate position between the clearly mentally healthy and the frankly mentally diseased. In each group one comes to feel that there is, at the back of the trouble, either a constitutional inadequacy or long-established faulty habits and attitudes hardly less fundamental. In (1) the psychoneurotics there appears to be a conflict within the individual—an emotional conflict that continually distracts and exhausts as in neurasthenia, that sporadically disrupts the personality as in hysteria, or fastens upon some act for purposes of vicarious expression as in psychasthenia. In (2) the emotionally unstable there is no deep working fairly stable conflict, but an uncontrolled variability or perverseness of emotional life. In (3) the group of "eccentrics" some peculiarity of emotional attitude has so dominated the entire personality as to warp and twist the individual's ideas and judgments into incongruity with reality.

. . . Now one last word regarding the larger significance of the subjects dealt with in this chapter. It is to be observed that these borderland conditions are not different in kind from conditions of normal mental life [1]—that study of these conditions gives one a new insight into one's own mental mechanisms; that these individuals so like the average person are numerous, to be met very frequently in everyday life, and present problems of social and economic adjustment which are insistent and of major importance. So important and ever-present are these problems that some understanding of the topics treated in this chapter ought to be common knowledge among intelligent people.

[1] It may seem that a distinction even of degree, between these cases and the average individual, can hardly be maintained—that in fact the chapter would permit the classification of almost any one in difficulty as borderland. The distinctions are not, of course, on the basis of any particular symptom but on the total picture, and especially the total trend of the personality as seen in the light of the full history. The matter of differential diagnosis will be returned to in Chapter XI.

CHAPTER VIII

THE FUNCTIONAL PSYCHOSES

Nature and Classification of the Psychoses

As has been repeatedly emphasized, the differentiation between a "borderland" condition and normality is frequently difficult; similarly is the differentiation often difficult between a "borderland" inadequacy and a mental disease. But, usually, there is much less trouble. A psychosis is a disorder involving a *change* of personality. A psychotic individual is no longer his old self. And the development of the disease can be followed in the history (if the history is at all adequate), with some definiteness.

It remains to be explained, however, just what a "change of the personality" may be. Perhaps the most important change —from the practical point of view at least—is a change in the person's mental organization, in his attitudes and systems of beliefs, in his bases for judgments. He is really no longer responsible. He is usually definitely deluded; and the presence of *delusions* may be considered a fundamental symptom of a psychotic condition. The delusions are, moreover, of great social importance, since the false ideas may lead to actions of a definitely anti-social nature. Besides the evidence of delusions, other symptoms may be looked for in the establishing the presence of a psychosis. The presence of hallucinations may be taken as important confirming evidence. An emotional extreme, whether of apathy, depression or excitement, is to be considered of great importance. Markedly peculiar actions are to be looked on with suspicion. In certain of the psychoses, special features of the bodily condition are of distinctive

significance. The fundamental facts for the beginner to understand are, however, two in number: the fact of change, and the fact that the personality is affected. (1) That is, a psychosis has, like any disease, a fairly definite history, with development of progressively more obvious symptoms. The history of the psychotic is thus to be distinguished from the history of the feeble-minded or temperamentally peculiar person where the condition is static. Further (2), the person's condition is such that he is not to be considered entirely responsible; his judgment, emotions, or self-control are so involved that he cannot conduct himself and his affairs in a reasonably prudent fashion. It is sometimes remarked that the person is not any longer himself. The psychotic are so distinguished from the neurotic conditions.

The reader who is familiar with standard manuals in psychiatry will doubtless be surprised at the small amount of space devoted to the psychoses in comparison to the attention devoted to the "borderland" conditions. There are several reasons for this shift in emphasis. In the first place, the borderland cases are more numerous. More can be done about such conditions in the way of treatment and of prevention. Further, the borderland cases are usually the major problem of the clinical psychologist, the personnel manager, or the social worker. They are met very frequently and they much more frequently have to be dealt with by such workers without assistance from a psychiatrist; the case of frank psychosis is (or should be) sent at once to a psychopathic hospital, or to a clinic for nervous and mental diseases, but the "borderland" conditions usually cannot thus readily be disposed of. Finally, these "borderland" conditions are distinctly more interesting from the standpoint of the general reader, who is interested in abnormal psychic conditions as a matter of natural interest in his everyday dealings with people. So the psychoses will be dealt with comparatively briefly.[1] The reader who wishes more about the unmistakably insane will find references to such material at the end of this section.

[1] It must not be concluded, however, that the psychoses are not a topic of importance to the general reader or to the social worker, personnel manager, or even the public school official. Such conditions are much more frequent than most people realize: and a psychotic individual is a major problem in any industrial or social situation in which he may be. The subject is important to the school man in two ways:

It will be noticed that the psychoses have been divided into two groups, the functional and the organic. The distinction is in some respects unfortunate; we may suppose an organic basis for all mental pathology. And it must be kept in mind, also, that the features of even the most crudely organic of psychotic conditions seem often to be determined more by the individual's original temperament and character—which the organic disease has merely let loose—than by the nature of the physical disease process itself. From a practical point of view, however, the distinction is convenient and well worth while. An organic psychosis is a mental disease in which some specific physical factor is the outstanding causative element in the condition; the patient has neurosyphilis, or cerebral arteriosclerosis, or hyperthyroidism. The disease has come upon the patient; it is not an integral development of his personality. On the other hand, in dementia præcox, in manic-depressive insanity, in paranoia, any physical changes *seem* (at least) secondary to the mental difficulty. And that difficulty is most readily expressible in characterological terms, and is explainable most naturally with reference to the person's total previous temperament and development. Further, the practical problem differs in the two groups. The organic psychoses present problems primarily medical, the functional psychoses problems primarily developmental and emotional. The approach is distinctly different.

The present chapter will, then, deal with three "functional" psychoses—dementia præcox, manic-depressive insanity, and paranoia—and will consider these conditions, so far as possible, as anomalies of temperament or development. As such, some relationship to the borderland functional difficulties mentioned in the previous chapter is naturally suggested. The close similarity between the paranoid trends, mentioned in the last

adolescent psychoses are by no means uncommon in the school population; and most of the psychoses develop from childhood and adolescent situations. It is interesting in this connection that the more education an individual has the more likely he is to become insane (see Chapter XIII).

section of the previous chapter, and paranoia is so obvious as to hardly need mention. Perhaps the emotionally unstable group is not ill described as the group of the chronic manias. The psychoneuroses and dementia præcox have many subtle common features. One naturally wishes, in fact, to see a genetic relationship between the three borderland functional difficulties and the three functional psychoses; the beginning psychosis often suggests a borderland condition under stress of which the individual has begun to "break." However, a majority of the borderland conditions appear to be static, rather than progressive. . . . It is easy to make too much of the relationship.

Dementia Præcox

No mental disease seems to the beginner so un-understandable as dementia præcox. Further, different forms present such different symptoms that it is difficult to grasp the disease as an entity.[1] But the subject will well repay close study. No other forms of mental derangement are so extraordinary. And study of these forms seems to be bringing a profoundness of insight into certain features of human character and personality which is of very great importance.

General Characteristics of Dementia Præcox. The beginner will do well to think of the psychosis as (1) primarily affective and characterized by a condition of apparent emotional indifference or apathy. This indifference is often very striking. The patient loses all interest in friends, family, in the career he had marked out for himself, is not even interested in being released from the hospital, but may sit idly all day, hardly glancing up, and paying no attention to what is going on about him.

The indifference is astoundingly present even when other features of the patient's condition are suggestive of a strong emotion. There may be great activity and even violence with

[1] In fact, it should perhaps be added that the concept already seems to be breaking up; but, for the purposes of the present text, a conservative treatment of the subject would seem best.

destructive tendencies and sudden assaults upon other patients. Nevertheless, there appears to be no motive for this violence; the patient can, afterwards, give no reason for the excitement, and the attack comes suddenly without any relationship to circumstances. The patient may have delusions of persecution which (one would expect) would bring about great emotional distress, and a desire for revenge upon the enemies responsible for his misfortunes. Nevertheless, these painful ideas are described in a monotone with apparent total indifference, and nothing whatever is done toward an adjustment of the fancied wrong. There is no emotional expression, rather a silly smile, appearing erratically when there is nothing to smile about, and queer facial contortions or tremors which suggest emotional expression somehow gone wrong. This extraordinary indifference of the patient and constant irrelevancy of feeling to idea and circumstance is the most striking, most pervasive, most uncomfortably unnatural feature of the disease.

(2) In contrast to this marked poverty of the emotional life is the relatively slight and late-appearing disorder in the intellectual sphere. So far as it can be determined (the patient's indifference, and the negativism later to be referred to, usually make him hard to investigate, and often wholly inaccessible), the memory is relatively little affected. Ideas acquired before the development of the psychosis are well retained and things going on about the patient in the hospital are frequently found, when a later remission brings the patient "to life" again, to have been much more closely observed than the indifferent manner would have led one to believe. There are usually hallucinations, most frequently auditory. And (the most striking feature in the intellectual sphere) there is an irrelevancy of association—a queer, awkward, stilted, disconnected character to the patient's thinking which has that same unnatural quality to it which was mentioned a moment ago in connection with the emotional condition.

The thinking is very superficial. There is a paucity of ideas. As if to cover up all this, there is much awkward use of long words, of labored and involved phrases, and a curious inco-

herence which sometimes make a patient wholly non-understandable. A totally irrelevant word may be injected into the middle of a sentence. A question may be answered by a statement wholly irrelevant. The patient may then ramble off into a series of sentences having no relation whatever to each other (so far as can be observed), and finally breaking up into a mere "word-salad," in which may appear absolute neologisms —words coined by the patient himself. One is reminded vaguely of a person tremendously excited; but instead there is behind it all that curious baffling indifference. The patient seems no more worked up than if he were discussing the weather.

(3) The appearance and behavior exhibit similar curious perversions. As would be expected from the patient's emotional tone, he is indifferent and careless as to his appearance, slovenly, not neat, and not healthy looking. The curious expressions, grimaces, and twitchings have been alluded to, also the erratic and unmotivated behavior. In particular, there may be automatic obedience or negativism. The first term is largely self-explanatory, but will be returned to later. The negativistic patient is a good deal like an obstinate, willful child; in fact, in mild conditions the similarity is rather striking. It develops to the extreme of contrariness. Tell the patient to open his eyes and he closes them; ask him to open his mouth and he clenches his teeth tight shut; tell him to get up and he will resist all attempts to get him out of bed. In fact, the best way to handle him is to tell him to do just the opposite of what one wishes him to do.

This negativism is carried to remarkable extremes. Perhaps the patient at table will not eat from his own plate, but instead will snatch things from a neighbor; or there may be persistent refusal of food which makes necessary tube feeding, sometimes through the nose as the mouth cannot be opened. The patient lies in bed in a peculiar posture, rigid, with face screwed up into a queer grimace, pays attention to nothing, even a severe pin-prick, refuses to eat, to go to the toilet—is as near a vegetative organism (apparently) as any human being could be. . . . These are of course extreme conditions.

However, a slight awkwardness and stiffness (as in shaking hands, for instance), a certain tendency to awkward and meaningless movements, and this queer contrariness or negativism, are to be looked for in any case of dementia præcox.

Study of the present condition thus may be expected to reveal three important symptoms, which have been given roughly in the order of their importance. (1) There is in the emotional life a strange indifference or apathy. (2) There is, intellectually, an inconsequentialness in association, a strange disconnectedness in the thinking and in the relation between ideas and emotion and between ideas and behavior; there is a sort of a "psychic ataxia." Finally, (3) the behavior shows also a perversion of function; there is awkwardness and constraint in movements, purposelessness or unnatural contra-activity—a tendency to do the opposite of the reaction naturally suggested in a given circumstance.

Study of the history reveals a fourth set of facts of some distinctive importance. The family history is likely to be definitely tainted; there is likely to be, in the family, a case or two of some similar disorder, or one or more of the siblings may be feeble-minded. Or, more likely still, the family in general is characterized by "nervousness," peculiarity, and a certain seclusiveness. However, the family history is not to be made too much of; plenty of cases come, most distressingly, from families apparently of the best type. The history of the individual, though, usually tells much more.

Investigation very likely shows that the patient was one of those children who develop slowly. Walking and talking were delayed and throughout childhood the patient was somewhat sickly. As a result of these circumstances, as a result too (very likely) of a home life somewhat constrained and lacking in spontaneity, and as a result also of an inherent lack of vigor, the childhood development is distinctly morbid. There is a development of what may perhaps best be described as a "shut-in" personality. As a result of these various special circumstances the child has few playfellows. He is inactive

and tends to substitute daydreaming for the vigorous games and outdoor interests of the average child. Not being overly healthy—and being cared for overly much—he tends to think altogether too much about his physical condition; and there is pretty sure to be an early morbid and brooding development of sex-curiosity. From all these circumstances little good can come. In fact, the situation soon becomes cumulative. Having too little contacts with other children, little experience in getting along with other children is acquired. Before long there is an inability to get along in company which makes social contacts a continual aggravation of the first difficulty. The youth feels ill at ease with others; very likely he is too lacking in vigor to compete on equal terms with companions of his own age. His morbid broodings over his sex problem shut him off still more and give him a feeling of moral, as well as physical, inferiority. Then comes adolescence. All emotional difficulties are intensified. The youngster finds his very self changed, and the whole world looks different; but the old troubles drag and hamper as never before. There is a neurasthenic period of depression and emotional bewilderment with which the family doctor vainly tries to deal by means of tonics, rest, the return from school or work to home, home care, and other methods of treatment from which the young man has already suffered overmuch. Finally he begins to "break." The individual's character disintegrates under the stress. Some pathological and more or less symbolic method of emotional discharge is hit upon, of which the peculiar actions and ideas mentioned in the preceding paragraph are incidental forms of expression.

This "shut-in" history, then, this "pre-dementia præcox" condition, is a fourth prime bit of evidence for the diagnosis of dementia præcox which may be looked for in the history of the individual. Not all cases show such a history. Some cases previous to the onset of the disease were precociously bright; but even in these cases there often appears to have been a strained and forced element in the precocity. The situation

was not stable, and evidences of early emotional and social difficulty can be made out in the background.

About the history of the present crisis (that is, the history of the disease) less need be said. As has doubtless been appreciated by the reader, the disease process usually seems but a natural outcome of the total previous life of the individual; and it may be almost impossible to tell when the actual disease began. In other cases there may appear to be a sudden onset. Looking back at the life history, however, signs pointing toward such a collapse can usually be found; a slow and insidious development of the disease is to be expected. There is usually presented an individual who has never been entirely healthy either physically or mentally, or emotionally. With the crisis of adolescence, or with some later crisis, either physical (as in child-birth) or emotional (as in some brooding sex-affair), there is first a neurasthenic condition, with disorder of the general health and general mental inadequacy. Gradually other more alarming symptoms appear. Throughout, the patient has probably been troubled by insomnia. There develops a marked uneasiness, and a break in all the everyday habits which give life a structure and orderliness and are of no little service in helping the average individual to "carry on" through times of emotional stress. The patient is awake all night and refuses to get up in the morning, he does not have his meals at regular times, has no regular physiological habits, and so suffers physically in consequence. He becomes excited over little or nothing and begins to do queer things, like shouting out of the window at night or suddenly attacking some member of the family. Very likely some such act is required before the family is brought to a realization of anything like the true state of affairs; and finally, with a great deal of misgiving and in a somewhat secret and shamefaced way—which is a heritage from the old days when mental disease was not looked upon as a disease but as a visitation—the case is sent to a state hospital or a sanitarium. Examination there brings the various facts of the history to their true

significance, and reveals some such general symptomatology as has been outlined above.

Types of Dementia Præcox. As a matter of fact, the condition from one præcox case to another may be very largely dissimilar; and a given præcox may show in succession widely varying states. These various types have been variously classified; and it is interesting that, the further study goes, the more types there tend to be. As most candid psychiatrists will admit, the most common type is the "mixed type." However, for descriptive purposes, a fourfold classification is convenient. One may then speak of simple dementia præcox, hebephrenia, catatonia and paranoid dementia præcox. Very briefly it may be said that simple dementia præcox is to be thought of as the basic (though not the most common) form. There is a simple deterioration, very gradual, characterized primarily by a general dilapidation of personality, superficiality, and irresponsibility. Perhaps the type can be best understood if it is mentioned that many tramps and hoboes are supposed to be old præcox dements.

A close study of the history (if an adequate history is available) will usually show some mild psychotic episode. There is a neurasthenic period with headaches, depression, transitory periods of excitement, perhaps a mild hallucinatory display and a few fleeting and incoherent delusions. The case comes out of this episode the listless ne'er-do-well described above, and either drifts off and disappears or remains a chronic burden to a troubled and uncomprehending family and community. Without the history it is practically impossible to distinguish such cases from the feeble-minded.

Hebephrenia shows a more abrupt onset, usually. There is much more of an active disease process. After a neurasthenic period, similar to that mentioned above, there develops a more marked depression, then a lively hallucinosis with unsystematized delusions of a changeable nature and oddities of conduct. As the condition settles down only fragments of the delusions are left; the hallucinations are little attended to, there is the

indifference and apathy, the looseness of thought, and the mannerisms, which have been mentioned as symptoms of any type of dementia præcox. Hebephrenia is the "insanity of silliness" and suggests, perhaps more than the other forms, a deterioration of character, superficiality, and general mental dilapidation.

Catatonic conditions are, superficially at least, very different. After a gradual development, progressing through depression, there appears either catatonic excitement or catatonic stupor. The excitement at first may suggest a manic attack; sometimes, in fact, it is impossible at the time to make the distinction. But catatonic excitement can usually be distinguished from the excitement of manic-depressive insanity if the major features of dementia præcox are kept in mind. Behind the catatonic excitement there is that apparent lack of any relevant emotion which distinguishes dementia præcox from other conditions. There is lack of the ready distractibility characteristic of manics. The excitement is not influenced by delusions or—apparently—ideationally motivated; and there is the monotonous repetition of movements of a purposeless character which is also distinctive of præcox conditions. The catatonic stupor has an equally artificial character to it. The patient is really conscious of what goes on, even though he may lie rigid and immovable in bed for weeks at a time. Negativism is marked and covers all types of stimuli, including the physiological needs. There is mutism and refusal of food. The patient also may assume peculiar positions or queer forced expressions. Alternating with the negativism may be times of pathological suggestibility during which the patient will imitate movements made in front of him, or hold positions in which his limbs may be placed until the upraised arm or the stretched out leg drops from exhaustion, or may repeat automatically any questions which may be asked.

The catatonic conditions are often strikingly bizarre and fantastic. The activity seems to be wholly unmotivated. The patient will walk rapidly back and forth within a certain

area or perhaps hop on one foot, may suddenly make a dangerous attack upon some other patient without any warning and without any reason. In fact such patients sometimes first come to the notice of the psychiatrist because of a homicidal attack upon some member of the family—an attack which, because of its sudden and unnatural character, is not unlikely to be successful. The stuporous conditions are equally enigmatic. The patient is not really stuporous in the ordinary sense of that word. After the attack the patient may be able to give in surprising detail the events during that strange period when he appeared to be oblivious to everything; and when asked, during the remission, why he behaved thus queerly, persisted in this or that peculiar gesture, he says that he does not know, that he simply did these things. After the acute episode is over, certain of these peculiarities usually remain as residuals. There are stereotyped attitudes mannerisms, and so on. During the attack there is often a striking breakdown of the ordinary reserves. The patient is exceedingly profane and exceedingly filthy in his language: and there remains a certain cheapness of character.

Paranoid dementia præcox begins as usual with a change of disposition, insomnia, impairment of health. And the fundamental dementia præcox symptoms are there, appearing more clearly as the condition progresses. But they are more or less concealed by an astounding display of incoherent delusionary ideas with accompanying hallucinations. The ideas are usually persecutory but may be primarily of a depressed nature.

The delusions may be almost entirely incoherent and may shift, develop, and then be replaced by other fancies, even while one watches; or there may be a fairly coherent system. Evidently as there is such a coherence there is likely to be a relatively consistent and stable condition; and one will expect a coherent system to develop rather more slowly than a system of delusionary ideas which have not been thus integrated. In fact, paranoid dementia præcox generally shows a rather slow

onset and a very gradual deterioration. But there is comparatively little hope of recovery. Gradually, with the deterioration, the delusions become more limited, the hallucinations less frequent and less vivid (or at least less attended to), and there remain simply a few last traces of the delusionary system (a paranoiac residue) to hint at the type of disease which brought about the patient's present condition.

So much then for the various forms of dementia præcox—to which this should again be added, that the conditions one sees are likely to be of a "mixed type" with symptoms suggesting more than one of the four forms.

Prognosis and Treatment. Now a word about prognosis and treatment. As suggested by the name of the disease, an irrecoverable dementia is usually expected, though it is not inevitable. There are almost sure to be remissions after the first acute attack, during which the patient improves remarkably. But he usually does not get back to his old self; there are residual traces of the disease left, if one only looks carefully enough—a silly inconsequential laugh, a lack of emotional vigor and lively interest, a certain shallowness of thought and an inconsequentialness, a certain constraint and awkwardness in movements. One has the feeling, too, that the patient is somehow frail mentally; a slight strain would start the whole thing over again. And so it usually turns out. After a while, there is another episode from which the patient recovers still less completely. And so there is a gradual stepping back into a condition of marked mental enfeeblement.

The impression must not be given, however, that there is progress toward physical weakness and death. The disease, in itself, is not fatal. There is a certain impairment of physical vigor and a consequent increased susceptibility to certain diseases, such as tuberculosis and pneumonia. The patient may live indefinitely, however, and our state hospitals are filled with these precocious dements.

Little has as yet been developed by way of treatment. The impaired physical condition of the acute attacks may be im-

proved somewhat by careful treatment and medication. Excitement may be cut down somewhat. There may be tube feeding upon refusal of food. There may be an occupational therapy—simple outdoor tasks like gardening may hold the progress of the deterioration somewhat in check. But little more can usually, at present, be hoped for. It should be said very emphatically, however, that hospital care is advisable. Regular habits help to hold the patient together and can be much better enforced in a hospital than at home. The physical condition can be much better looked after in an institution. The patient can there best be occupied with tasks suitable to his condition. On the other hand, if kept at home, the patient's condition is aggravated. The treatment he receives is less wisely adjusted to his condition. If other members of the family are also somewhat unstable (as is likely to be true), the presence of the patient in the family may be perilous to the mental health of all the other members of the family circle.

As has been implied, recent work suggests that dementia præcox is perhaps best to be understood largely in psychogenetic terms and that early difficulties of emotional adjustment, particularly with reference to sex problems, may be the important etiological factors. Further, it appears possible to explain the extraordinary symptoms of præcox in terms of reaction to these emotional problems.[1] In proportion as there is such intimate understanding of the condition, an intelligent therapy evidently becomes possible. And as a matter of fact, treatment based on these theories seems often to be extraordinarily successful (a further discussion of treatment will be found in the chapter on that subject). But these last theories are hardly well enough established to find a place in the present text. They are not, either, theories for the amateur to play with. The school official, social worker, or personnel

[1] So the patient's indifference to what is going on about him may be understood as due to the fact that he has withdrawn into a world of daydreams, in which he is obtaining imagined satisfaction of his suppressed desires. The mannerisms may be considered acts of emotional symbolism. The silliness may be a reaction to the imaginary sex experiences. The catatonic rigidity may be considered an attitude of resistance to the suppressed desires, and the catatonic excitement a combat with these feelings.

manager will (the writers believe) find it best to keep to the general point of view of the preceding pages—and certainly, when he suspects that a case is suffering from dementia præcox, turn the individual at once over to a psychiatrist.

The following cases will illustrate the four types of dementia præcox described above.

Case No. 15

Name: Frances M. *Age*: 18. *Sex*: Female. *Birthplace*: Chicago. Single. *Sources of information*: girl, college teachers, college acquaintances.

I. History of the Family.
Nothing is known except that the family was wealthy and had no real home, simply living at some hotel. They had always lived in hotels since the patient can remember.

II. History of the Individual.
A. Medical—Was never very robust.
B. Social—During high school did not get along with people. Went on solitary walks frequently. Had no friends. During her college course, she was extremely active in religious affairs; became very excited at times. Frequently developed a most passionate affection for some prominent girl and literally dogged her footsteps. Was *very* dirty. She used to pick the dandruff out of her scalp and eat it, and the dirt from her ears, during the chapel service. Her room was filthy; she would not allow the maid to clean it and she would not touch it herself. She had no pictures or ornaments of any kind in her room. Everyone cordially disliked her and avoided her whenever possible. She used to go out for a walk each morning before classes began; she would start up one path, go a short distance, then run back and start up another. Sometimes she would make three or four false starts before deciding which way she would go.
C. Educational—She was in college and doing fair work. She had periods when she refused to work at all, and would lie all day in bed looking at the ceiling.
D. Economic—Had never done any work.

III. History of the Present Crisis—None during the time the individual was known to the writers.

IV. Present Condition.
A. Physical.
General Health—Seems to be in poor health. Has cold, clammy hands. Bad breath. Doesn't keep clean.
Special Defects—Defective vision—almost cross-eyed.

B. Appearance and Behavior—Is untidy and slovenly and dirty. Has a stiff, awkward gait. Uses stiff gestures a good deal. Frequently seems to be hurried and harassed. Talks as if she were delivering an oration. Is frequently seen listening and otherwise reacting as if to hallucinations.

C. Intellectual Condition.
General Level—Above average in intelligence.
Special Function Disorders.
Judgment: seems to be becoming disorganized. Attention: very poor. Memory: apparently fair, but she doesn't seem to remember girls she has met several times. Association: is very erratic. She talks quite a good deal at times, particularly in religious meetings, but her remarks lack coherence. Intake: apparently hears voices telling her what to do.

D. Emotional Condition.
General Emotional Tone—Usually apathetic, but once in a while an outburst of great excitement.
Special Emotional Trends—None evident except her wild "crushes."
Emotional Conflicts—Her attachments to other members of her own sex have a suspicious look.

V. Summary and Conclusion.

A. Summary—Poor general health. Cyanosis. Solitary childhood and adolescence. No friends; passionate adorations. Dirty and slovenly; no care of self or room. Periods of refusal to do anything. Hears voices. Apathy, alternating with periods of excitement. Poor attention. Incoherence. Stiff and pompous; mannerisms.

B. Conclusion—Dementia Præcox—Hebephrenic form.[1]

Case No. 16

Name: Elsie D. *Age*: 18. *Sex*: Female. Single. *Sources of information*: girl, parents, family doctor, teachers, hospital records.

I. History of the Family.

A. Medical—One aunt and a cousin were insane. No insanity in immediate family.

B. Social—Nothing found.

[1] The case may serve to illustrate the fact, mentioned in the first chapter, that mental difficulties—even frank psychoses—are by no means rare among college students. And such cases are often handled very stupidly and unintelligently by the college authorities. Neurotic conditions are very common. A neurasthenic condition just following graduation—an expression of the emotional difficulties involved in adjustment to the real world after the four years of college life—is especially frequent.

C. Educational—Grade school education.
D. Economic—Father keeps a small store.

II. History of the Individual.
A. Medical—Has never been strong and vigorous. Has always been underweight.
B. Social—Got on fairly well with others, but had no intimate friends. Never sought friendship with others.
C. Educational—Is ready to enter the third year of high school; school work average.
D. Economic—Has as yet had no employment.

III. History of the Present Crisis.
A. Medical—After a few days of depression and headache was seized with violent attack of excitement. Threw herself around the room and screamed, beat her head against the wall. Then became stuporous.
B. Social—Had been becoming indifferent for some little time. Had had periods of an hour or more during which she sat immovable in a chair; during these times she would not speak or eat or pay attention to anything.
C. Educational—Stopped going to school about a week ago.
D. Economic—Nothing.

IV. Present Condition.
A. Physical—Patient lies in bed, her muscles rigid. Her hands are extended down at her sides the fists clinched. Her jaws are set and cannot be pried apart. She is entirely mute. Her body can be placed upon two chairs so that her head is on one and her feet on the other and the body does not bend.
B. Appearance and Behavior—Patient lies in bed, rigid. Refuses to take food. Retains her urine and fæces.
C. Intellectual Condition.
General Level—Impossible to determine.
Special Functional Disorders—She gives no sign whatever; appears to be wholly unconscious.
D. Emotional Condition—Difficult to determine; appears both negativistic and fearful.

V. Summary and Conclusion.
A. Summary—Brief episodes of apathy, inaccessibility, and negativism, then a period of violent, purposeless excitement (catatonic excitement). Now a stuporous condition. Is mute and rigid. Refusal of food; retention of urine and fæces.
B. Conclusion—Dementia Præcox: Catatonic stupor.[1]

[1] After some time in this condition, the girl had another attack of excitement; she behaved as before and became dangerous, suddenly

CASE No. 17

Name: Harry M. *Age*: 23. *Sex*: Male. *Birthplace*: a small town in New England. Single. *Sources of information*: patient, mother, brother, local doctor, hospital records.

I. History of the Family.
   A. Medical—Father was insane. One uncle was very eccentric.
   B. Social—Had a stepfather who was cruel to the children; teased and made fun of them.
   C. Educational—Less than grade school education.
   D. Economic—Father was a clerk in a bank.

II. History of the Individual.
   A. Medical—Normal.
   B. Social—Is the youngest of six children. Has been his mother's favorite. Has never mixed with other young people much; especially shy of girls. What few friends he has had have been older men. Has masturbated for some years.
   C. Educational—Has gone part way through High School.
   D. Economic—Has worked as clerk since leaving school.

III. History of the Present Crisis.
   A. Medical—Has had headaches and queer "pains" in his body. Has heard strange clickings and buzzings. Recently has been hearing threatening "voices." Has been very tired and half-sick for about a month.
   B. Social—Is positive that his stepfather is trying to get rid of him. Some days he would not touch food because he feared it was poisoned. Would get "simply wild" if any one spoke in low tones near him as he felt he was being talked about. Has not been out on the street for two or three weeks because everyone "talked about him." Won't let his mother salt his food because he thinks she is putting in poison. Sits alone for hours at a time, then suddenly reacts to auditory hallucinations with evidences of fear. Blames his stepfather and thinks his stepfather shoots electric currents through him.
   C. Educational—Nothing.
   D. Economic—Hasn't worked for nearly a month.

IV. Present Condition.
   A. Physical.
      General Health—Poor general health. Indigestion and constipation. Underweight.
      Special Defects—No special defects.

attacking persons who came near her. Following this she had a remission of about a year and returned to the hospital again in a stuporous condition.

B. Appearance and Behavior—Is either sitting apathetically looking in front of him, or else is moving about trying to get away from the voices he hears. Is getting quieter and less excitable right along; doesn't react as violently as he did at first.

C. Intellectual Condition.
General Level—Probably about average. At present, gains an I.Q. of only 76, but was too distracted during examination to do his best.
Special Functional Disorders—Judgment—some deterioration with ideas of reference and clear delusions of persecution. Attention very difficult to attract. Memory about normal. Association eccentric; makes irrelevant answers to questions. Intake: hallucinations of hearing and touch. Hears voices accusing him of sex perversions.

D. Emotional Condition.
General Emotional Tone—Apathetic, a little surface excitement. Sometimes a little silliness. Often seems bewildered.
Special Emotional Trends—Seems dominated at times by fear; occasionally becomes panic-stricken for a few moments.
Emotional Conflicts—Some conflict is apparently going on, something that the patient feels he cannot face. He says that the voices accuse him of sex perversions.

V. Summary and Conclusion.

A. Summary—Friendships with older men. Favorite child of mother. Morbid fear of stepfather. Seclusiveness and suspiciousness—paranoid attitude. Indigestion and constipation. Headaches and shooting pains. Poor general health. Auditory hallucinations. Some schizophrenia. Evidences of conflict over sex matters. Ideas of reference. Delusions of persecution. Apathy with a little surface excitement.

B. Conclusion—Dementia Præcox—Paranoid form.

Case No. 18

Name: Pauline S. *Age*: 18. *Sex*: Female. Single. *Sources of information*: father, stepmother, teachers, family doctor, hospital records.

I. History of the Family.

A. Medical—Mother died at birth. Three or four cases of insanity in collateral branches. One brother subnormal.

B. Social—Very critical, jealous stepmother.

C. Educational—Parents had grammar school education.

D. Economic—Father a mechanic.

II. History of the Individual.

A. Medical—Has never been vigorous. Walked and talked a little late.

B. Social—Has always been seclusive and eccentric. For two or three years has had periods of lying in bed refusing to eat or talk. Has had sex relations with younger brother since she was seven years old. Has rarely played with other children and has never asked others to come to her house. Has always gone to school and returned from school alone. For several years has preferred to daydream rather than play games.
C. Educational—Finished eighth grade, but never tried to go to high school.
D. Economic—Has never done anything; practically never helped with household work.

III. History of the Present Crisis.
A. Medical—Became pregnant—and has had a child recently.
B. Social—Has just had a child, whose father is her brother. Has continued sex relations: but the boy had matured. Has been getting more and more slack and dirty in her personal habits. Is seclusive and sits for hours without moving or speaking. There has been no recent character change. She has simply become more and more apathetic and inactive.
C. Educational—Nothing.
D. Economic—Does less and less to help in the housework, or even to look after herself.

IV. Present Condition.
A. Physical.
General Health—Sallow, sickly appearance. Cyanosis. Poor digestion. Foul breath.
Special Defects—No special defects.
B. Appearance and Behavior—Sits quietly. Has some mannerisms. Occasionally shows a little purposeless restlessness. Giggles and grimaces at odd moments. Sometimes lies in bed for days, noticing nothing. Is slightly negativistic, but always succumbs to a little urging.
C. Intellectual Condition.
General Level—Impossible to determine, but is now probably rather definitely below average.
Special Functional Disorders—Judgment: seems to have only very vague or fleeting delusions. Attention—very difficult to attract—in fact, the girl is almost inaccessible. Association very eccentric. Answers often not relevant. Emotions are not relevant to idea. Intake seems to be normal. May have an occasional hallucination.
D. Emotional Condition.
General Emotional Tone—Very apathetic.
Special Emotional Trends—None evident.
Emotional Conflicts—If there is any conflict it is well cov-

ered up—She seems to have given in completely to her fancies and to be enjoying them.

V. Summary and Conclusion.
A. Summary—Long history of incest, and of gradually developing apathy, seclusiveness and inaccessibility. Recent childbirth; the father is her younger brother. Unhealthy appearance. Dirty personal habits. Economic inefficiency. Now apathy, silliness, inaccessibility, irrelevancy of thought. Silly and inconsequential conversation. Some mannerisms and slight negativism. Slow character change.
B. Conclusion—Dementia Simplex—(possibly hebephrenic).

Manic-Depressive Insanity

It was suggested a few pages back that there is a certain similarity between the three "borderland" conditions described in the preceding chapter and the three functional psychoses here treated. The second of these "borderland" conditions was characterized particularly by emotional instability. Manic-depressive insanity may be characterized as the psychosis of emotional extremes.

That is, as with dementia præcox, the outstanding symptoms are to be found in the emotional field. In mania, there is great emotional liveliness, good humor, and self-satisfaction. Certain cases remind one strongly of a person happily drunk. There is nothing of the indifference or emotional irrelevancy of the præcox; the patient's emotional attitudes are very alert, he is very sensitive to emotional situations and responds beautifully and extravagantly. . . . Or—the other extreme of this strangely compounded disease entity—the patient is extremely depressed, overwhelmed with the blackest melancholy, anxious to make away with himself and willing to use the most cruel means, if only freedom from the sorrows of this world may be obtained.

As might be inferred from the name of the disease, there is no dementia. Essentially the individual's intellectual capacities are unimpaired. They are dominated by the emotional condition, of course, and such dominance may carry the manic into half-playful delusions of a euphoric character. Or the re-

pressed patient may develop ideas of a very distressing kind as a rationalization of his depressed mood. Flow of ideas is facilitated in mania and retarded in depression. However, there may be an extraordinarily logical development of the depressed ideas; intellectual traits are less affected than one might think, to observe the case.

Behavior is coherent with the emotional condition. The manic is extraordinarily active and boisterous, is likely to be showily dressed, extravagant in behavior, most friendly in handshake and speech, marvelously alert to everything that is going on about him, ready in repartee, touched off to action by any incident. The depressed case, on the contrary, is inactive, extremely slow in speech and movement, hesitant, perhaps actually stuporous, as though fairly drugged or worn out by the terribleness of his emotion. It should be noticed, however, that in either condition there is nothing of that unnaturalness and awkwardness which is the peculiarly uncomfortable feature in the behavior of a præcox. The manic-depressive case is always somehow understandable. The præcox is not.[1]

A manic-depressive case shows, then, (1) first of all, emotional excitement or depression. (2) There is little intellectual disturbance except as this may be secondary to the emotional upset. The most striking feature so far as the intellect is concerned is a facilitation or retardation in the flow of ideas. (3) There is, correlative with the emotional condition, a motor excitement, or a retardation which may verge into stupor. Finally, (4) the history of the individual may, as with dementia præcox, be expected to contribute much to the diagnosis. For that matter, the family history may be expected to assist greatly. Manic-depressive insanity is *the* strikingly inherited psychosis. Similar periods of excitement or depression are to be looked for in the history of one or the other of the parents, also further back and in the siblings. Suicides and periodic alcoholics appearing in the family his-

[1] At least, not readily understandable by those without intimate knowledge of psychopathology.

tory are almost sure to be cases of manic-depressive insanity, thus reacting to their emotional disturbances. In fact, over and over again it turns out that one may almost diagnose the daughter's trouble on the basis of the mother's history. The patient's history, however, is the important thing.

The manic-depressive individual usually has exhibited his emotionality, and particularly a certain periodicity of emotional condition, from childhood. There are periods of great activity when the individual is very capable, is one of those persons who "gets things done" splendidly, is active in social affairs and possessed of an abundant energy. Such conditions alternate with periods of depression or, at least, of intellectual and physical retardation. There is a marked weariness, some melancholy; the patient may stay in bed for several weeks together. That is, the individual is one of those people who "has his ups and downs." Then, perhaps at adolescence, perhaps later (rarely in childhood), the whole business becomes more acute and the individual finds himself hurried into a condition where he is no longer his old self and is no longer under his own control. As has been suggested, a hypomanic reminds one of a person mildly drunk. The first attack may be of this nature. Perhaps more likely, the first attack was a depression which became alarming to the family only when the patient attempted suicide. After a few weeks or months, however, the condition wears off, perhaps after a brief transit into the other extreme (that is, the depressed case may pass through a period of excitement back to normality). And after the attack has thus passed the patient is normal again.

For a year, five years, or ten, the individual is well. Then, because of stress, or for no reason at all, there is another attack. It is in this succession of similar attacks, with a complete recovery between, that the important characteristic of manic-depressive insanity appears. In considering a diagnosis of manic-depressive, then, one must look for the symptoms mentioned above and especially for a history of previous attacks of a similar nature, followed by complete recovery.

In other words, the prognosis is good, so far as the individual attack is concerned, but other attacks are to be expected. Treatment for a given attack consists primarily in rest, with perhaps other special measures, such as prolonged warm baths, to cut down excitement. The depressed case must be watched to prevent suicide. There is little medication. However, a soporific may be needed to control insomnia. And something should be done for the loss of flesh and constipation usual in the depressed phase; the physical condition must be carefully watched.

The individual who has once had an attack must be warned to be careful in the future. Over-fatigue must be avoided, and excitement, so far as possible; and the individual should learn to recognize the early symptoms of an attack so that he may get himself under supervision before the condition fully develops. As a matter of fact, manic-depressive cases often do thus present themselves at a hospital. Such individuals may turn up with fair regularity every few years with a touch of excitement, amuse and delight the hospital for a while, perhaps then go through a depressed period, and then return to the world again.

So much for the type conditions. But the psychiatrist is always finding himself under the necessity of acknowledging "mixed forms." Thus there may be retardation without depression. Particularly important is a condition of depression with excitement occurring at the involution period and often described separately as "involution melancholia."

There is intense psychic pain. The unhappiness may seem to overwhelm the patient into an almost stuporous condition. More commonly the melancholy is expressed in great emotional agitation; the patient walks up and down the corridor as in a daze, wringing her hands, weeping, and saying over and over to herself, "Oh, my God! Oh, my God! Oh, my God!"

The condition may be probably best understood as an attack of manic-depressive insanity brought on, or at least much

aggravated, by the climacteric or the general changes in the physiology appearing with the beginning of old age. Such changes are too profound to yield to treatment; the condition can be only mildly alleviated. Suicide may be prevented, the strength kept as best may be, agitation calmed as much as possible, and special attention given to the alimentation. An extended duration of the attack may naturally be expected, or death from inter-current disease, which finds an easy victim in the wasted physique. If nothing of this sort happens, ultimate recovery is rather more probable than not.

The following case will illustrate both the manic and the depressed phases of this disease.

CASE No. 19

Name: Albert M. *Age*: 46. *Sex*: Male. *Birthplace*: Maryland. Single. *Sources of information*: patient, recent employers, hospital records.

I. History of the Family.
   A. Medical—Nothing known.
   B. Social—Patient was an illegitimate child; never knew who his father was. Mother deserted child; her whereabouts unknown.
   C. Educational—Nothing known.
   D. Economic—Nothing known.

II. History of the Individual.
   A. Medical—Patient has never been very vigorous, but has always been nervously quick and somewhat irritable. Has been considered as moody and somewhat irresponsible since childhood. Was admitted to an insane hospital at 17 years of age with a manic attack. Since that time has had two attacks of depression and one further attack of a manic nature. During the two depressions the patient was confined in some hospital.
   B. Social—Has always been a wanderer. Was a truant from school, going off on journeys. Has traveled with circuses. Employed in minor parts in vaudeville. Has been from San Francisco to Boston seven times, getting jobs as his money was used up, then going on to the next stop. Usually works around a theater, if possible. Drinks considerably. Is unmarried.
   C. Educational—Completed grade school work and has had three or four spasms of attending night schools.

D. Economic—Has been in vaudeville, and in a few road shows. When such employment cannot be obtained, he has been scene shifter, taken part in mob scenes, etc. Has changed positions so many times that no accurate account may be obtained.

III. History of Present Crisis.

A. Medical—Felt an attack coming on for over a week before it became explicit. Stopped his work—failing to turn up at a matinée without giving any notice—and went on a spree, which helped precipitate the attack.

B. Social—Was arrested for being intoxicated and sent to the hospital by the police.

C. Educational—Nothing.

D. Economic—Dropped work when attack became imminent. For several days before he had been inserting comic bits into his very minor part and had been reprimanded for so doing. Manager complained that the patient had "monopolized the scene" to the disgust of the principals.

IV. Present Condition.

A. Physical.

General Health—Good. Shows flushed cheeks, increased heart rate, increased reflexes, but no serious condition, although he will become worn out if his activity is not reduced.

Special Defects—None.

B. Appearance and Behavior—Talkative. Makes jokes continually. Laughs and sings. Skips up and down the wards; occasionally executes a clog or other dance step. Is a perfect clown. Conversation shows an inclination towards a humorous, but not offensive, profanity. Gives every appearance of having a wonderful time. The casual onlooker would say he was drunk.

C. Intellectual Condition.

General Level—Patient "clowned" his way through the mental examination, but nevertheless earned an I.Q. of 95. Probably his true mental ability is rather above the average, though his present rapidity of thought and fluency of expression may have operated to raise his I.Q. Certainly he possesses at least average intelligence.

Special Functional Disorders—Judgment—shows very poor organization; he is flighty. Attention is exceedingly poor, cannot be held on anything for more than a moment. Highly distractible. Memory seems normal. Association is extremely rapid, but shows no irrelevancy. Intake—normal.

D. Emotional Condition.

General Emotional Tone—Excited; overemotional.

Special Emotional Trends—Apparently dominated by happy emotions—euphoric.
Emotional Conflict—There seems to be little evidence of conflict. At least the patient shows no evidence of inhibitions.

V. Summary and Conclusion.
A. Summary—History of previous attacks, moody disposition, roving habits, frequent change of occupation, alcoholism; acceleration of physiological processes, increased reflexes, excitement (of a happy sort), activity, highly distractible attention, very rapid association.
B. Conclusion—Manic-Depressive Insanity (Manic Phase).

Case No. 20

(This is a study of the same individual portrayed in Case 19, during a second admission to the State Hospital, about six months later. The material under the first two headings will not be repeated.)

III. History of the Present Crisis.
A. Medical—Has been feeling sick for two weeks. Began to drink heavily, but did not seem to get rid of his discomfort, so stopped rather suddenly a day or so before the attack came on. Attempted suicide by asphyxiation.
B. Social—Has been sullen and depressed for about two weeks. Has been very seclusive, shunning the company of others, whereas he usually wants company. After stopping drinking, says he tried "religion," by going to an evening revival service. The excitement of the revival apparently precipitated the suicidal attack.
C. Educational—Nothing.
D. Economic—Has not been working for over a week. Says he stopped because he felt so tired.

IV. Present Condition.
A. Physical Condition.
General Health—Is underweight; has lost 20 pounds since previous admission. Slow pulse, constipation, insomnia. Complains of extreme fatigue. Diminished reflexes.
Special Defects—None.
B. Appearance and Behavior—Sits dejectedly, arms hanging at sides, facial muscles relaxed, shoulders slumped forward. Glances slowly and hopelessly about him. Does not speak unless questioned. Sits motionless for hours.
C. Intellectual Condition.
General Level—I.Q. has dropped to 75. Again the results are not to be trusted, as he would not even attempt many questions.

Special Functional Disorders—Judgment—shows a centering of thought about his emotional discomfort. Attention hard to attract. Memory seems normal, when any answer at all can be elicited. Associations are painfully slow, but answers are relevant when they finally come. Intake apparently about normal.

D. Emotional Condition.
General Emotional Tone—Extremely depressed.
Special Emotional Trends—Dominated by unhappy emotions.
Emotional Conflicts—Appears to be numbed with the excess of his emotion. No conflict can be found at present. There may be something that precipitates the attacks of excitement or depression, but nothing appears.

V. Summary and Conclusion.
A. Summary—Previous attacks, moody disposition, roving habits, frequent change of occupation, alcoholism, suicidal attempts; underweight, slow pulse, diminished reflexes, insomnia, constipation, fatigue; depression, slow association, concentration on melancholy feelings.
B. Conclusion—Manic-Depressive Insanity (Depressed Phase).

Case No. 21

Name: Franklin W. *Sex*: Male. *Age*: 58. *Birthplace*: New England. Married, one daughter. *Sources of information*: wife, daughter, employer.

I. History of the Family.
A. Medical—Father committed suicide. One sister neurasthenic.
B. Social—Middle class people.
C. Educational—Grammar school education.
D. Economic—Father a mechanic.

II. History of the Individual.
A. Medical—Had a rather typical "manic-depressive temperament," but no attacks of any severity.
B. Social—Was usually an exceedingly good mixer but was occasionally "grouchy" and "inclined to religion." Has been noted for his sudden changes in mood. Employer says he was sometimes very irritable. Would occasionally "resign" his job, but would come back the next day as though nothing had happened.
C. Educational—Grade school education.
D. Economic—Was a mechanic.

III. History of the Present Crisis.
A. Medical—Became very depressed. Attempted suicide by hanging himself with the cord of his bathrobe. Later on,

attempted suicide again by cutting his wrists with the edge of a tobacco can; nearly bled to death. No appetite. Insomnia and headaches.

B. Social—Has been seclusive and religious for about two weeks. Has an idea that he has committed the "unforgivable sin," but seems unable to tell definitely what this sin was. Talks about this "sin" to the exclusion of all else.

C. Educational—Nothing.

D. Economic—Work about as usual, but a little slow.

IV. Present Condition.

A. Physical—Underweight. White-haired. Hard arteries. Impotent.

B. Appearance and Behavior—Wanders about or lies in his bed crying. Wrings his hands. Groans under the burden of his "sin." Occasionally becomes agitated and cries out sharply, or suddenly sits up, with arms upraised, calling for mercy. Sometimes appears to be driven from place to place in the ward by his thoughts; but usually he sits fairly quietly or lies in bed—his activity being restricted to restlessness. Appears to be benumbed by his mental anguish.

C. Intellectual Condition.

General Level—Fair.

Special Functional Disorders—Judgment—shows thoughts centering around ideas that he has committed some sin; this is a very vague delusion, but a persistent one, and seems to be the result of an attempt to rationalize his depression. Attention—very difficult to attract. Over-concentration on his troubles. Memory—apparently normal. Association—slow and seemingly painful, but perfectly relevant. Intake—normal.

D. Emotional Condition.

General Emotional Tone—Over-emotional.

Special Emotional Trends—Seems dominated by anguish and tormenting worry.

Emotional Conflicts—No evidence for any "unforgivable sin." This idea is apparently a rationalization of his extreme depression—an attempt to find a cause for a condition that he cannot understand.

V. Summary and Conclusion.

A. Summary—Attempted suicides. Depression. Signs of senescence. Loss of weight. Over-religiousness. Delusion of the "unforgivable sin." Agitated depression. Appearance of great mental anguish.

B. Conclusion—Involution melancholia.

Paranoia and Related Conditions

Mention has already been made of paranoid dementia præcox, and of borderland paranoid conditions characterized primarily by feelings of suspicion developing a warped and essentially false series of ideas with regard to the patient's own importance and relation to the world at large. As appeared in the section on borderland conditions, the paranoid case was to be considered first of all as constitutionally psychopathic or the product of a markedly abnormal home and social environment (usually both), and as dominated by "eccentricity" (or better, "egocentricity") to such an extent that the judgments and beliefs were warped in consequence. We may, perhaps, characterize paranoid dementia præcox as a combination of such a paranoid condition with precocious dementia. In such a combination one would expect the paranoid ideas to be loosely organized and fantastic because of the coincident mental deterioration. The present section deals briefly with those paranoid conditions in which the dementia is either negligible or long delayed, but in which the delusions are so unmistakable that the patient is to be considered clearly psychotic; that is, the section deals with what is sometimes called true paranoia as distinguished from paranoid dementia præcox or paranoid conditions appearing in other psychoses. True paranoia is comparatively rare. But here, as elsewhere, there are no hard and fast distinctions. The general characteristics of marked paranoid conditions will, therefore, be described. Some rough classification will then be attempted.

We may perhaps suppose at the base of the mental constitution, which later develops a paranoid system, a fundamental weakness which should appear in the family history; there should be in the family history the suggestion of mental instability or peculiarity. However, paranoia develops late; an adequate family history is thus often difficult to obtain. It is only in the history of the individual, then, that an adequate picture of the mental constitution from which the

paranoia develops can be obtained. The patient has probably had a medical history which is negligible; there are no physical correlates to the mental disease. Nor are symptomatic difficulties to be looked for in the history of the patient's achievement. In fact, one might almost say that some little mental capacity was required for the systematic development of an elaborate delusional system. The case of true paranoia is thus likely to show a good school record (if this record is obtainable) and a reasonable business ability up to the time when the paranoid condition flowered to such an extent as to interfere with routine activities. It is especially in the social history that the facts important for the understanding of the mental condition are to be found.

As was said in the discussion of the borderland paranoid conditions, one may expect the eccentric individual to develop in a family not showing entirely normal and healthy social relations; and one may expect the patient to exhibit, early in life, a certain artificiality in his relations to other people, a certain conceit and egotism, and a markedly suspicious nature. Such traits might, in a reasonably well socialized individual, receive a thorough disciplining at the hands of playmates in childhood and associates in later life. But for one reason or another social contacts have been limited—or the individual's peculiarities have been incorrigible or have made social contacts largely impossible. Very likely they have carried him into circumstances where much living by himself has given further opportunity for the development of the trouble; he has, perhaps, entered business in a foreign country, where the circle of his acquaintances was of necessity small, or has of his own volition largely cut himself off from other than business relationships with other people.

We have, then, an individual conceited and self-centered, very suspicious and (as a result of temperament or circumstances) living a largely isolated existence. A morbid development of the two traits just mentioned can hardly be considered unexpected.

Such development may, perhaps, begin (following some emotional or nervous strain) with a period of a neurasthenic nature, with headaches, insomnia, weakness, nervousness and a marked hypochondria. There is also depression. Gradually, from this condition of persistent emotional irritability and discomfort, mental symptoms begin to emerge. The patient begins to express his discomfort in terms of ideas more or less explanatory of this feeling-state. The individual is unhappy because he is being unfairly treated. He is being talked about behind his back; any buzz of conversation has, for him, vague remarks regarding him and his affairs. That is, there are "ideas of reference"—the first stage, one might suppose, in a development of delusions.

Very soon these ideas do develop into actual delusions of persecution. All his physical discomfort, the remarks about himself which he believes he hears, any difficulties in business (perhaps due to the condition of mental stress) are always referred to the operation of some enemy, who is endeavoring in all these devious ways to force him to some repugnant act, or bring about his destruction.

All these ideas may now be further backed up by definite hallucinations of hearing. The person no longer merely misinterprets bits of conversation which he actually hears; he hears voices, unmistakably hallucinatory, which make remarks about him in keeping with his delusionary notions, and so fortify him in his false beliefs. There is not the slightest doubt, now, that the Freemasons, the Jesuits, the Black Hand, or John Jones (his rival in business), are most maliciously attempting his ruin in most extraordinary ways. Agents of the enemy follow him about, prejudice people against him, interfere with business transactions, perhaps poison his food or send electric currents through him at night.

Such experiences are surely most unfortunate, and the patient does all he can to thwart his enemies or protect himself. He moves from place to place trying to flee from his enemies (he may appeal to the police, which is a happy circumstance,

as the police have an unerring eye for the "nuts" and will bundle the patient off to an asylum at once). Various means are also taken to interfere with the malignant influences; the bed is insulated, no food is taken until others have eaten of it, etc. The patient finally, in desperation, turns upon his persecutors—and we have a most dangerous lunatic. For it must be made clear that the patient shows little deterioration; he is still reasonably clear-headed, and may plan the destruction of his supposed enemy with the greatest cunning. Nor does the patient suffer from the indifference of the dementia præcox. He is highly indignant and resentful over the persecution.

If the patient escapes recognition during this second stage, a third stage may develop, not unreasonably related to the second. The patient comes to pondering why he should be thus persecuted; there must be some motive. And the motive is found in his own importance. He is really of royal birth; he is possessed of great wealth or is otherwise an especial object of attention—and we have a gradual development of expansive delusions, with an accompanying change of attitude toward a certain complacency and self-satisfaction. . . .

The description given above is of a special type of paranoid development and is rather schematic than typical; the development may stop at any one of the stages mentioned, or there may be a combination of the various stages. The important thing to notice is that, from the point of view of the patient, there is a certain coherency in the development. We have in such conditions a peculiar temperament which comes to dominate the intellectual processes. Naturally the intellect suffers in such a situation and there is more or less of a final dementia. But the course of the disease is very prolonged, the development exceedingly insidious; there may be nothing of the emotional dullness seen in dementia præcox. The patient is also likely to conceal his symptoms very shrewdly, with a suspiciousness characteristic of the condition. In proportion, then, as the case is a case of true paranoia (that is, paranoia without the presence of any other pathological conditions), one

has an individual who is largely intact mentally and emotionally, but is nevertheless under the control of ideas essentially untrue. It is obvious that no type of insane individual can be more dangerous.

When such a case finally lands in a hospital for the insane, a study of the present condition usually yields results somewhat as follows: A medical examination is negative. Emotionally, the patient is somewhat irritable, testy, self-important—particularly when personal affairs are touched upon—but good-natured when humored. Intellectually the striking feature is the systematic delusional system. This delusional system may be so closely interwoven with actual experiences that it is simply impossible to tell fact from fancy; it is generally the monstrousness of the final conclusion that is patently pathological. Or the delusions may be relatively unsystematized with the incongruities unmistakable to everyone but the patient; it all depends upon the patient's original mental capacity and on the extent to which the patient has suffered, intellectually, in the course of the disease. The memory is but little affected. The patient is likely to construe all facts in his previous history with reference to his delusions, however, to such an extent that one comes to feel sure that there must be some retroactive falsification of memory—that the patient has made over some of his memory material, unconsciously, so that it may figure in his delusionary ideas. Association is fairly ready; the patient's thinking is a bit loose and shallow, but there is no striking defect. In true paranoia there are no hallucinations; but in paranoid conditions closely related, as paraphrenia, hallucinations may be prominent. Appearance and behavior usually show little that is abnormal. The patient is somewhat pompous and self-important—but, then, so are many other people!

It should be obvious that there is little in the way of treatment that is possible for such a condition, developing over a period of years, and quite as much a flowering of a peculiar personality as an actual disease process. The condition may

develop to a point where the person is socially and economically impossible, and must be confined in an asylum to prevent his being more or less of a general nuisance if not an actual danger. Such confinement is not always necessary, however; individuals of the litigious type (who try to right their supposed wrongs by interminable lawsuits) may do nothing worse than get themselves more and more into debt. The "crazy" inventors and reformers may do nothing worse than burden their families, even though essentially psychotic. Probably also most of the cases of true paranoia never come to a hospital, but get along somehow, and are only recognized as queer.

The following case will serve to illustrate these relatively rare conditions:

CASE NO. 22

Name: Charles M. *Age*: 60. *Sex*: Male. Born in rural Indiana. Widower. *Sources of information*: the man himself, son, neighbors.

I. History of the Family.
   A. Medical—Normal.
   B. Social—Normal.
   C. Educational—Illiterate.
   D. Economic—Were moderately successful farmers.

II. History of the Individual.
   A. Medical—Normal.
   B. Social—Has always been extremely religious. Is a Catholic. Has covered the walls of his house with "holy" portraits, crucifixes, etc. Had an altar built in his living-room. When he was about forty, he conceived the idea that he would be a great man, if he could only get to some city where he would be appreciated. He rented his farm, left his wife and boy with relatives and went to Chicago, feeling that he was fulfilling a "call." Five years later he returned, convinced that everyone in the city was plotting against him. He believes that the time will come when everyone will realize his greatness. For about the last ten years, has occasionally, after much praying and fasting, heard a voice calling him to become a follower of Christ. Since his wife's death, about five years ago, he has given his farm to his son and has moved into a near-by city to retire into a holy life. He spends most of his time in the Cathedral at prayers. He says that he has the power to communicate with any dead person; claims that he sits on the right hand of God

and that the angels will do his bidding. Says he can hear angels sing and that he can see Christ on the cross. Spends most of his day in prayer and devotion.

C. Educational—Had a grammar school education.

D. Economic—Owned a large farm and became moderately wealthy. Before he retired he bought the house he now lives in, and is living on his income.

III. History of the Present Crisis—None.

IV. Present Condition.

A. Physical.

General Condition—He shows some signs of senility, white hair, tottering gait, and partial deafness. Is rather stooped and thin from constant fasting. Bears scars of self-inflicted torture.

Special Defects—Partial deafness.

B. Appearance and Behavior—Spends most of the time praying. Walks about with arms folded across his chest in the sign of the cross. Talks considerably, but always on religious matters. Has a pompous air and important manner. Talks as if he were giving commands. Is stiff and domineering.

C. Intellectual Condition.

General Level—Probably about average.

Special Functional Disorders—Judgment—completely dominated by religious ideas and delusions. Attention—excellent where anything religious is concerned, but impossible to distract from this channel. Memory—unimpaired. Association—normal. Intake—occasional experiences of an apparently hallucinatory nature.

D. Emotional Condition.

General Tone—Overemotional and sentimental.

Special Emotional Trends—Dominated by religious fervor. Fanatic.

Emotional Conflicts—None determined.

V. Summary and Conclusions.

A. Summary—Approaching old age; underweight, gradual development (through "paranoid" period) of religious fanaticism. Now complete domination by religious ideas; religious delusions. Questionable hallucinations. Deports himself in a pompous manner that he thinks is fitting for one of his high position.

B. Diagnosis—Paranoia.

The functional psychoses are the most serious, the most difficult to deal with, and the most mysterious of all the ab-

normal mental conditions. These diseases are (in order of importance): (1) dementia præcox, (2) manic depressive insanity, and (3) paranoia. The chapter has endeavored to give some general understanding with regard to these difficult topics. But it should be thoroughly appreciated that the discussion has been simply to give such general understanding; no one but an expert should attempt to deal with persons suffering from such conditions. When dementia præcox, manic depressive insanity, or paranoia is suspected, the case should be turned over to a psychiatrist—at once.

CHAPTER IX

THE ORGANIC PSYCHOSES

The three psychoses described in the preceding chapter are essentially anomalies of character or development. The conditions to be described in the present chapter are to be thought of rather as mental correlates of certain conditions of physical disease. The conditions will be described very briefly; the one important thing for the personnel manager, clinical psychologist, or social worker to know is the essentially medical nature of the difficulty—then send the case to a physician.

General Paresis

The most important condition to be described in this chapter is general paresis. And the one important thing to remember about general paresis is that it is due to syphilis. So heredity is essentially unimportant—except as the family history may suggest a type of temperament, in the family, of the free and easy sort which might be expected to acquire syphilis. The history of the individual is unimportant also, except as the history may relate to the sex affairs which led to the acquirement of the disease. As a matter of fact cases of general paresis show all kinds of personal history previous to the onset of the mental condition; however, some relationship is sometimes suggested between alcoholism or other debilitating factors and tendency to develop neurosyphilis, once syphilis has been acquired.[1]

[1] Of course not all syphilitics develop paresis. Just what factors predispose to such an end is not known. There may possibly be some obscure hereditary weakness. More likely (as suggested above) alcoholism or other influences lowering the resistance of the nervous system will be found important.

Study of the individual's history and temperament is important primarily, as such study may indicate something of the type of breakdown which may be expected. The disease appears to release from control the elements of the individual's nature rather more than to have characteristic mental features of its own.

So, quite in contrast to the cases presented in the previous chapters, the significant history begins with the history of the present crisis. The patient has probably come to the hospital as a result of a gradually increasing mental inability with change of character. Very likely he has made business blunders of a peculiarly unfortunate sort, has invested his money extravagantly and without judgment (with the result that he finally leaves his family in financial straits). Or there has been a moral degeneration of a very crude type—much sexual indulgence and alcoholism without regard for appearances. Finally, either the family or business associates realize that something is wrong, and a physician is seen.

The physician finds, first of all, certain physical symptoms. There have been headaches, insomnia, attacks of dizziness, or perhaps a convulsive attack or seizure. Physical examination shows certain distinctive signs. The pupils do not react normally to light. The knee-jerks are either greatly increased or diminished. The speech is very blurred; syllables are either left out altogether or repeated several times; the test phrase, "Methodist Episcopal" becomes "Methodistical" or "Methodisdistipal." This slurring and poor enunciation becomes worse as the disease progresses, until the babblings are entirely non-understandable. The writing suffers in a similar manner. Syllables and words are omitted; the writing is erratic and irregular; it becomes progressively worse until it is just a series of illegible flourishes. Such physical symptoms are strongly suggestive. The history of syphilitic infection is always inquired after. If the patient is frank, a history of such an infection some time previous (usually ten to twenty years) is found. A sample of blood is taken for a Wassermann

reaction, and a sample from the spinal fluid by means of a lumbar puncture. All the laboratory reactions of these samples are usually found to be positive, and the diagnosis is made: general paresis; prognosis—progressive dementia and death probably within the next three years.

As the disease develops, various forms are distinguishable. The form probably depends chiefly upon the character of the patient, which the disease releases from control and disintegrates, rather than upon any specific effect of the disease itself. Four forms are often described. They are to be thought of as type conditions rather than distinct entities—the mixed or intermediate forms are the most common.

The "demented" form is characterized chiefly by rather rapid deterioration, almost without remissions. The patients are exceedingly forgetful, restless, and lacking in judgment. They are likely to have paralytic attacks. They rarely become as emaciated as the other forms.

The "expansive" form is characterized by expansive delusions, a rather gradual course, and the likelihood of several remissions. The patient is talkative, energetic, and has a marked feeling of well being. He has many grandiose delusions—he is the strongest man in the world, he has all the money there is, he feels better than he ever did, he can lift ten tons, he can compose beautiful poems, he has a marvelous invention, he has a gold mine in Alaska, etc., etc., *ad lib.* One patient has a train that encircles the globe in twelve hours; another has been married two thousand times and has twenty-one hundred children; while a third has dug a canal through from the United States to China and is making money selling the million pounds of opium sent by this method:—and so it goes. The patient's consciousness becomes somewhat clouded and he is exceedingly self-centered. He is usually cheerful and expansive, but easily becomes irritable. These patients sometimes become excited and rush about shouting, swearing and singing. The mental deterioration is fairly gradual, usually covering a period of at least two years.

The "agitated" form is chiefly characterized by its sudden onset, its superlatively expansive delusions, and its short course; it is, in fact, a sort of sub-group of the "expansive" form. The individual becomes restless and is constantly in action, running about, pounding the wall, telling stories which are like the delusions presented

above, only more extreme and usually of a less cheerful nature, until the disease has progressed so far that he can only lie on the bed, making babblings and inarticulate sounds. The consciousness becomes very clouded soon after the onset. This profound clouding plus the extreme excitement lead to a total collapse, sometimes in a few weeks. There are frequent paralytic attacks. Physically, the patient becomes emaciated, troubled with bed sores, and dirty.

The "depressed" form is characterized by a very gradual onset and by a feeling of depression with delusions of a melancholy nature. The patient is very hypochondrical, believes his brain is rotting away, or that his stomach is gone, or that some other such unfortunate state of affairs has taken place. The patient's consciousness soon becomes clouded and he spends hours in stupor. Remissions rarely occur and the course of the disease is usually rather less than two years.

The general course of the disease may be briefly indicated. There is the period of first development, followed (more or less immediately) by a period in which the symptoms are very acute; this in turn melts into a final stage of complete deterioration and paralysis, during which the patient is utterly apathetic, dirty and paralyzed—simply a breathing wreck.

The prognosis is very poor; death usually occurs in less than three years. The treatment consists primarily in keeping the patient as comfortable and clean as possible, in keeping him nourished, and in preventing him from injuring himself or others. Various forms of special treatment, as with salvarsan, neo-salvarsan, have been much experimented with. Such treatments appear often of some efficacy. They sometimes hold the disease in check for a period, but seem not to cure it.[1]

The disease is of great importance from a social point of view. It is comparatively common, causing around 10 to 15% of all admissions to state hospitals, and strikes in the prime of life—a great majority of cases beginning between thirty and sixty. It also frequently shows itself first in errors of judgment which bring business reverses, or in gross indulgences which bring disgrace to the family before the cause is under-

[1] Recent experimentation, the most unique involving use of malaria to fight the infection, does seem promising, however.

stood. So, much hardship is worked; the family is left penniless; business is impaired—other individuals are almost sure to suffer.

This is altogether aside from the possibility of syphilitic infection of wife or of children. Many women thus contract syphilis and in some instances develop general paresis. Feeblemindedness or juvenile paresis may develop in the children. General paresis is the climax in the series of ills for which syphilis may be responsible.[1]

The following case is fairly typical. The reader should note the striking contrast, as regards family and personal history, to the cases of functional psychosis described in the previous chapter.

CASE NO. 23

Name: Derwin S. *Age*: 54. *Sex*: Male. *Birthplace*: Massachusetts. Married. *Sources of information*: wife, brother, business partner, family doctor.

I. History of the Family.
   A. Medical—Nothing of importance.
   B. Social—Family very prominent society people in large eastern city. Very wealthy. One of the city's historic families.
   C. Educational—Father, two uncles, and brother all college graduates.
   D. Economic—Had been bankers or prominent professional men for generations.

II. History of the Individual.
   A. Medical—Nothing of importance.
   B. Social—Had been reckless and headstrong in youth; period of sowing "wild oats." Has been slightly alcoholic since. Once kept a woman in an apartment for a time. At about thirty settled down to work, married, and has been entirely respectable since.
   C. Educational—Is a college graduate.
   D. Economic—Was a successful banker and broker.

III. History of the Present Crisis.
   A. Medical—Has been having headaches, insomnia and general malaise for a couple of months. Recently had a sort of

[1] In this series are also to be counted, of nervous and mental diseases, tabes dorsalis and various forms of cerebral syphilis.

shock. Had a brief period of depression a few days ago during which he thought he was dead and buried.

B. Social—Has given evidence of confusion of mind by appearing for breakfast in pajamas, and by other odd acts. Has forgotten important social engagements.

C. Educational—Nothing.

D. Economic—Has recently made several investments of a most suspicious nature. During the last two weeks has been playing stocks recklessly. Has lost considerable money, a good deal of which did not belong to him. The last few days has become hesitant and worried; can't seem to make up his mind.

IV. Present Condition.

A. Physical Condition.
Appears rather worn out and older than his age would warrant—white hair, etc. Double positive Wassermann and spinal fluid. Pupils irregular. Gait is shuffling. Positive Romberg. No knee-jerks. One leg drags a bit as he walks.

B. Appearance and Behavior.
Roamed about the ward in a bewildered fashion at first. Since the first day or two has been developing a grandiose manner, and an exaggerated cheerfulness. Tells everyone he is nearly well again and will be back at his office in a day or two. Brags about the money he has, saying he will give each person a hundred million, etc.

C. Intellectual Condition.
General Level—Has been rather high, but he gains an I.Q. of only 86, indicating deterioration.
Special Functional Disorders—Judgment—some vague delusions that his family is trying to get rid of him. Ideas that he is enormously wealthy, has thousands of children, etc. Attention—rather difficult to hold, though easy to attract. Memory—distinctly poor for both present and past events. Association—about normal, but slow. Sometimes irrelevant. Intake—apparently normal.

D. Emotional Condition.
General Emotional Tone—Is at present somewhat overexcitable.
Special Emotional Trends—Has been depressed, but is now happy and jovial.
Emotional Conflicts—None evident.

V. Summary and Conclusion.

A. Summary—History of sexual irregularity and of some alcoholism. Recently headaches, insomnia, "shock," also depression with fantastic delusion, forgetfulness, loss of judgment, bewilderment. Has positive Wassermann and spinal fluid,

neurological findings. Marked euphoria with grandiose delusions.

B. Conclusion—General Paresis, mixed form, but with grandiose elements predominating.

The Toxic Psychoses

A variety of abnormal conditions may result from excessive use of alcohol.

The family of a person suffering from *chronic alcoholism* is likely to be alcoholic and defective. In general, the potential sufferer from an alcoholic psychosis has inherited a peculiar lack of resistance to the disease. He is perhaps not a particularly heavy drinker, but is extremely susceptible to the drug.

The individual's history is sure to be one of alcoholic indulgence. Gradually his mental faculties become impaired; his memory is especially poor. His moral sense becomes blunted and he no longer has any ambition; he will do almost anything to obtain his liquor; he loses all affection for his family and all sense of honor. Physically, he develops a fine tremor, a characteristic uncertainty of gait, and slurring speech, and is likely to have seizures or periods of vertigo.

Treatment consists chiefly in complete abstinence from alcohol. Such abstinence, however, is likely to last very little beyond the time of confinement in a hospital or other institution. The patient is too much weakened, physically, mentally and morally, to resist the temptation to fall back, once more, upon the stimulus or the forgetfulness of the drug. In fact the patient is likely to be, constitutionally, either too inadequate or too unstable to be capable of any such self-control. Prognosis is, thus, poor; the chronic alcoholic is a chronic problem.

A large per cent of chronic alcoholics show some further pathological developments. These are rather of an episodic nature and usually disappear after the withdrawal of the alcohol.

In *delirium tremens* the chief symptoms are the sudden

development of very fantastic hallucinations especially of sight and touch with vague delusions of fear and a moderate clouding of consciousness. The attack comes on rather suddenly, after a few days of restlessness, with extremely vivid hallucinations in which the patient sees snakes, rats, devils, or crowds of people; he feels insects crawling over him, and is usually terrified by his visions and the cries and shrieks that he seems to hear. The patient's consciousness becomes clouded and he cannot apprehend the objects about him, nor can he recognize his friends. He is likely to react to his hallucinations and delusions—trying to run from the crowds he sees, answering the voices and trying to rid himself of the vermin he feels crawling over him. There is always insomnia and a general restlessness.

The prognosis is almost entirely favorable unless the patient collapses from physical exhaustion; prolonged baths are very useful in cutting down the restlessness and preventing such an outcome. The trouble is to be thought of, primarily, as simply an episode in the life of a chronic alcoholic.

Alcoholic hallucinosis is characterized chiefly by auditory hallucinations of a threatening character, around which are grouped a system of delusions of persecution, the consciousness being clear. The patient hears voices reviling him or plotting against him. He is sure these voices belong to certain people of his acquaintance and interprets the threats as proving that he is surrounded by enemies instead of friends. His emotional state is one of apprehension and fear. The prognosis is good, as practically all cases recover—that is, they return to the state of chronic alcoholism.

A variety of other conditions may develop in connection with alcoholism. In fact, reactions to alcohol are even more varied than the forms of general paresis, and suggest again that the form which the mental disease takes is determined quite as largely by the individual's original make-up and character as by the disease process itself—even where that disease process is brought about by such crude factors as alcohol

or syphilis. Among these various conditions may be mentioned alcoholic-pseudo-paresis—which can hardly be distinguished clinically from true paresis. There may be alcoholic epilepsy which is, as far as the individual attacks are concerned, indistinguishable from true epilepsy. It must be remembered also, in this connection, that alcohol is likely to increase the severity of epileptic disturbances and that alcoholic excesses are common in epileptic crises. Alcoholic paranoid conditions are also fairly frequent; the characteristic delusion is of marital infidelity. The development of such delusions of jealousy is, in fact, almost distinctive of alcoholic delusionary conditions and may very often be a result of alcoholic impotence.

Korsakow's psychosis deserves special mention; the condition is not always of alcoholic origin, but is most commonly thus brought about—is likely to appear as a residue after delirium tremens. The striking feature is the peculiar falsification of memory, or "romancing." There is almost no memory of recent events; but, without being intentionally deceptive, the patient fills in the gaps with the most extraordinarily detailed fabrications—which are narrated with the characteristic good humor and loquacity of the alcoholic and with a composure and assurance which is almost convincing. The stock question is to ask the patient, first of all, about his breakfast. One is likely to have detailed a long bill-of-fare quite out of keeping with the actual simple rations of a state hospital. Asked what he did yesterday, the patient will tell you about business transactions downtown and a grand spree with friends the night before, although he has been in bed in the hospital for the last three weeks.

Other conditions may be of a relatively fleeting and incidental character; there may be conditions of trance, automatism, double personality followed by amnesia. It is also important to note again that alcoholic conditions may be combined with epileptic episodes, with manic-depressive states. Alcoholism may be primarily a symptom of a constitutional psychopathic condition. The impulse to drink may, in fact, more frequently than not, be considered an evidence of a neuropathic taint or of mental defect; and in such cases, psychotic conditions come with surprising readiness under the influence of

alcohol. There is a morbid hankering for alcohol and a morbid susceptibility to it. . . . This probable complicatedness of the situation must never be forgotten.

The following two reports will give a rough idea of the general characteristics of the alcoholic case.

Case No. 24

Name: Archie L. *Age*: 41. *Sex*: Male. *Birthplace*: Ireland. Married. *Sources of information*: wife, son, aunt, neighbors.

I. History of the Family.
- A. Medical—Alcoholic family. Father, uncle and brother are all drunkards.
- B. Social—Constant dispute over drinking. Considerable family dissension on the matter.
- C. Educational—Almost illiterate.
- D. Economic—Family of Irish day laborers.

II. History of the Individual.
- A. Medical—Has been drinking since he was sixteen or seventeen. Always excitable and nervous.
- B. Social—Doesn't get on well with his immediate family, who disapprove of his drinking.
- C. Educational—Left school in the 6th grade, poor work while there.
- D. Economic—Day laborer. Very irregular occupation.

III. History of the Present Crisis.
- A. Medical—Has been becoming more and more irresponsible. Memory sometimes fails him. Has been slowly deteriorating. Used to have periods of sobriety, but has been drinking steadily for some months now. Family have tried persuasion and have become worried over his inability to leave the stuff alone. Has lied to them several times about the extent of his indulgence. Has nightmares. Will do anything to get liquor.
- B. Social—Troubles with family over the alcohol question. Has stolen money from members of the family to buy drink.
- C. Educational—Nothing.
- D. Economic—Hasn't been working for over a month.

IV. Present Condition.
- A. Physical Condition.

  General Health—Red face and considerable puffy fatness. High blood pressure. Alcoholic breath. Indigestion. Fine tremors of hands. Stumbling gait.

  Special Defects—No special defects.

B. Appearance and Behavior.
Somewhat overactive, but awkward in movements. Uses familiar, jovial tone with everyone. Talks considerably.
C. Intellectual Condition.
General Level—I.Q. of 60, but shows great "scattering" on examination, indicating that level was once higher.
Special Functional Disorders—Judgment—Fairly normal. No delusions. Attention—flighty. Memory—defective. Shows paucity of ideas. Association—about normal; a little accelerated. Intake—some suggestion of vague visual hallucinations, but nothing definite.
D. Emotional Condition.
Rather euphoric, typical cheap good nature of the alcoholic —but with readily aroused irritability.

V. Summary and Conclusion.
A. Summary—Family alcoholic. Patient has long alcoholic history. Shows tremor, high blood pressure, awkwardness, indigestion; poor memory, moral deterioration (steals from family to obtain drink), euphoria, possibly some visual hallucinations.
B. Conclusion—Chronic alcoholism.

Case No. 25

Name: Thomas B. *Age*: 34. *Sex*: Male. *Birthplace*: Ohio. Single. *Sources of information*: patient, mother, brother, family doctor.

I. History of the Family.
A. Medical—Neither of the parents drink, but both grandparents and one older brother were drunkards. One grandfather died in insane hospital.
B. Social—Normal.
C. Educational—Grammar school education.
D. Economic—Fairly well-to-do business people—upper middle class. Father owns a good-sized store.

II. History of the Individual.
A. Medical—Has been drinking rather heavily for two or three years.
B. Social—Did not drink much until nearly thirty, when the girl he was in love with married some one else (at least this is the excuse given). Has been a heavy drinker since. Always drinks alone. Becomes morose and ugly when drunk. Is sometimes destructive and abusive.
C. Educational—Graduated from grade school; average record.
D. Economic—Small tradesman. Good business man when sober. Neglects business to lie in bed and drink.

III. History of the Present Crisis.
- A. Medical—Heard voices threatening him at night. Threw all the furniture in his room out of the window, thinking he would injure the people outside who were talking about him. Became very much frightened and called in the police to protect him, as his enemies were about to kill him.
- B. Social—Is frightened. Thinks his family may be trying to poison him. Noisy and destructive.
- C. Educational—Nothing.
- D. Economic—Afraid to go to work for fear "enemies" will kill him.

IV. Present Condition.
- A. Physical.
  Poorly nourished. Fine tremors of hands. Some general unsteadiness of movement.
- B. Appearance and Behavior—Constantly active. Goes from room to room trying to find some place where he can't hear the voices. Is agitated, groans and looks about him in frightened way. Gives the impression of a man goaded to distraction by fear.
- C. Intellectual Condition.
  General Level—About average.
  Special Functional Disorders—Judgment—has various delusions that he is to be poisoned, that his family are against him, etc. Attention—very difficult to distract his mind from his troubles. Memory—apparently about normal. Association—reasonably normal. Intake—constantly hears voices threatening him and calling him vile names.
- D. Emotional Condition.
  Is overemotional and agitated. Marked worry and fear.

V. Summary and Conclusion.
- A. Summary—Some alcoholism in family. Patient has history of much solitary drinking, neglect of work. Has delusions of persecution and auditory hallucinations of a frightening and threatening nature. Physically shows tremor, unsteadiness; poor general physical condition.
- B. Conclusion—Alcoholic Hallucinosis.

A thorough understanding of the conditions produced by alcohol used to be absolutely necessary for a social worker, personnel manager, clinical psychologist, or other investigator, because the chronic alcoholic was so common. He is still to be found even in these days of national prohibition, however; and an adequate understanding of his mental condition should help in the prevention of criminal acts by these individuals

and in the realization—which comes to many a worker only after long and discouraging experience—that chronic alcoholics, however appealing they may be to one's charitable feelings, are seldom to be "cured." A sojourn in a home for inebriates can be tried; but it must be realized that after release the patient usually returns to his drink sooner or later.

Other "intoxication" psychoses are due to the constant use of drugs—particularly morphine and cocaine. Any investigator should be able to recognize the stigmata accompanying the use of these drugs and should understand the mental condition of the habitué, that he may realize the essential hopelessness of some cases and the possibility of recovery in others.

Many, if not most, users of drugs have a family and individual history showing degeneracy. Almost all people have to be given a dose or two of morphine sometime during their lives for the relief of pain; but it is especially those who are constitutionally defective who continue the use of the drug and become slaves to it.

The history of the psychosis usually shows an experimental period, during which the individual employs morphine to increase his flow of ideas or to give himself pleasurable dreams and visions. Frequently he tries, during this time, to break off the use of the drug—but he seldom succeeds. Soon he drifts into constant use of the poison and develops the permanent symptoms of the habitué. The patient is apathetic and listless; he becomes morally degraded—like the alcoholic—and cannot be trusted, as he will do absolutely *anything* to get his daily dose of the drug. In fact, he develops a most thorough state of moral degradation. He loses all interest in life, has no will-power, has very poor memory. He complains of dizziness and noises in his ears. Quite early in the disease the drug affects the stomach so that it will not retain food; the patient has no appetite and loses weight rapidly. Finally he becomes emaciated, is more and more demented and confused and—at last—overstrains his heart through intercurrent disease or an overdose of the drug, and dies.

The following is a fairly typical morphine case.

CASE No. 26

Name: Lucy C. *Age*: 27. *Sex*: Female. *Birthplace*: Illinois. Single. *Sources of information*: patient, sister, head nurse under whom patient had worked.

I. History of the Family.
   A. Medical—Mother a "nervous invalid."
   B. Social—Mother's neurotic personality has kept the family from having many friends.
   C. Educational—Father a high school graduate; mother never went to school regularly.
   D. Economic—Upper middle-class family. Father a wholesale grocer.

II. History of the Individual.
   A. Medical—Has never been very robust or vigorous. Some stomach trouble.
   B. Social—Has been somewhat unstable emotionally from childhood. Never made any very close friends.
   C. Educational—Finished high school. Took a nurse's training.
   D. Economic—Has been a successful nurse.

III. History of the Present Crisis.
   A. Medical—First used morphine after an accident in which she sustained several fractures. Has used it ever since in increasingly large doses. Has lost her appetite and is thin to emaciation.
   B. Social—Has stolen morphine from hospital dispensaries until detected about six months ago. Was discharged from hospital and has done nothing since. Had some money and a good supply of the drug. Recently has forged a couple of prescriptions—being familiar with the handwriting of several doctors.
   C. Educational—Nothing.
   D. Economic—Hasn't been nursing for six months.

IV. Present Condition (upon admittance, before treatment).
   A. Physical—Extreme emaciation. Shooting pains in limbs. Very weak reflexes. No appetite. Extreme constipation. High temperature and rapid, feeble pulse. Pin-point pupils.
   B. Appearance and Behavior—Very sloppily dressed. Dirty. Talks in loud, harsh voice. Seems apprehensive.
   C. Intellectual Condition.
      General Level—Does well on intelligence tests, obtaining an I.Q. of 95, in spite of weak attention and considerable exhaustion.

Special Functional Disorders—Judgment—has unsystematized and changing delusions of a weak sort that people are trying to injure her and are causing the pains she feels in her limbs. Flightiness; almost delirium. Attention—almost impossible to hold. Memory—poor. Association—eccentric. Little logical sequence to thought. Intake—fleeting visual hallucinations—spots and flashes of light.

D. Emotional Condition.
General Emotional Tone—Underemotional but irritable, apathetic.
Special Emotional Trends—None evident.
Emotional Conflicts—None evident.

V. Summary and Conclusion.

A. Summary—History of morphine with progressing economic incompetence and moral degeneracy. Emaciation. Loss of appetite. Constipation. Pains in limbs. High temperature; feeble pulse. Pin-point pupils. Vague delusions and fleeting visual hallucinations. Unstable attention, erratic sequence of thought—suggestions of an approaching delirium.

B. Conclusion—Psychosis due to use of morphine.

The use of cocaine gives very similar results,—a period of acute, pleasurable intoxication, followed by a chronic condition characterized by hallucinations, flight of ideas, general motor excitement, and irritability.

In either case, the only treatment is the gradual, or sudden, cessation of the drug. Inasmuch as the withdrawal of the poison renders the individual dangerously ill, it is seldom advisable to attempt this save in a hospital. The prognosis is usually poor; where there is any real degree of moral degradation there is practically no hope of a permanent recovery. In fact, the neuropathic soil which frequently is the factor making possible the slavery to the drug makes a complete recovery practically impossible; besides any weakness due to the drug there is also an hereditary weakness of character.

One other type of "intoxication" psychosis might be mentioned for the benefit of those who have to deal with men in industry. Any person who has been working with mercury, lead or arsenic and develops headaches, dizziness, mild delirium, hallucinations or attacks of an epileptic nature is very likely to be suffering from poisoning from one of these sub-

stances. Painters and dyers are constantly using these chemicals and need to be protected from them. Wherever there is a history of frequent contact with these chemicals, an acute state of intoxication should be suspected and the worker sent at once to a physician.

Senile Psychoses

Individuals with senile psychoses are characterized on the mental side by childishness, loss of immediate memory (coupled with a very exact memory for the events of childhood and youth), a tendency to reminisce, irritability, selfishness, and a desire to have everything about themselves continue as it always has been. The physical symptoms are those of old age—white hair, wrinkled skin, wasted muscles, and hardening of the superficial arteries. Some people reach a condition of physical and intellectual enfeeblement much earlier than others.

The family and individual history are not likely to show anything of great importance. The condition develops through a gradual appearance of childish irritability and an inability to understand the things of the present. Upon this general, weakened, mental basis delusions of a persecutory nature are likely to develop. These delusions, with the accompanying loss of memory, emotional outbursts or apathy, and loss of the capacity for apprehending new ideas, indicate a state of considerable mental deterioration. The delusions never become systematized because of the mental dilapidation, and the patient stays in a condition of complaining resistance to everything that goes on around him. In the course of the disease, epileptiform and apoplectic seizures are likely to occur.

The disease is progressive until death. Many patients reach a condition of complete dementia—they know no one about them, are confused, indifferent to everything, can remember nothing. Death usually occurs from pneumonia or other intercurrent disease that the patient is too old and worn out to resist.

The following case may be considered fairly typical.

CASE No. 27

Name: Caroline R. *Age*: 81. *Sex*: Female. *Birthplace*: Vermont. Married. *Sources of information*: son, son's wife, family doctor, nurse who was with patient three months.

I. History of the Family.
   A. Medical—Normal, as far as known.
   B. Social—Normal apparently; average people in their New England farming community.
   C. Educational—Rural school education.
   D. Economic—New England farming people.

II. History of the Individual.
   A. Medical—Had six children. Was well until she developed a benign growth upon her left temple—about five years ago.
   B. Social—Has always been of a complaining nature. Was irritable and suspicious. For five years has lived with married son and has made life miserable for son's wife.
   C. Educational—Country school education, apparently about average for her time.
   D. Economic—Was a good housewife.

III. History of the Present Crisis.
   A. Medical—Has been getting very feeble. Has had one or two shocks recently.
   B. Social—Has been a great care for over a year. Has been confined to her bed part of the time. Complained constantly of everything. Was most forgetful. Became dirty in her personal habits. Was increasingly childish and irritable.
   C. Educational—Nothing.
   D. Economic—Has been too irresponsible to do any housework for over a year.

IV. Present Condition.
   A. Physical Condition—Emaciated. Is bedridden. Cancer on face. Valvular trouble. All the signs of senescence. Had toenails averaging four or five inches long. Was most unwilling to have them cut.
   B. Appearance and Behavior—Lies in bed. Moves hands about fretfully. Speaks in a whining, complaining manner; talks a great deal in a wandering fashion. Takes little interest in anything.
   C. Intellectual Condition.
      General Level—Is too fretful and suspicious to test (supposing that were desirable). Probably was of about average intelligence.
      Special Functional Disorders—Judgment—disorganized;

somewhat demented. Feels sure that her children have put her in an institution to get rid of her. Attention—very wandering. Can't talk on the point. Memory—very poor—is very circumscribed in her reminiscences. Association—slow. Intake—normal.

D. Emotional Condition—Irritable, childish and silly. Petty displays of temper. At times suspicious and bewildered.

V. Summary and Conclusions.

A. Summary—Benign growth. Bedridden condition. Valvular trouble. Signs of senescence, childishness, forgetfulness, dirtiness in personal habits. Incoherence and wandering in conversation. Apathy or a childish irritability.

B. Conclusion—Senile dementia.

Gross Brain Disease

Sclerosis of the cerebral arteries results in a condition of more or less dementia. The mental symptoms are, at first, easy fatigue, insomnia, slight failure of the memory, dizziness and headaches, irritability and ideas of a paranoid or hypochondriacal nature. Some cases never develop further than this, but remain more or less static in this somewhat confused condition. But other cases are progressive. There are likely to be focal signs—that is, loss of movement in some part of the body, loss of speech, sight, or hearing—which indicate local lesions in the brain. The sclerosis may become general, resulting in a profound dementia.

The heredity and life history of these cases are, for the most part, negative. The individual is an elderly person who has been showing a more or less progressive intellectual impairment. The disease is very likely to be accompanied by senile decay. In fact, it is frequently impossible to tell these two conditions of advanced age apart. Most "seniles" have some arteriosclerosis. And a final dementia in old age may be the result of general physical and nervous decay or of a progressive hardening of the cerebral arteries. Many involution melancholias also develop arteriosclerosis and become demented; others begin a process of senile decay before recovering from their depression.

The prognosis of the disease is poor. Usually the patient

becomes considerably demented. Treatment should regulate the diet and take all physical and mental strain from the cardiovascular system.

Other conditions of gross brain disease need only the barest mention. Brain tumors are distinguished and located by the focal signs—neurological evidences, in loss of certain reflexes or local paralyses—due to lesions in certain specific areas of the brain tissue. By means of the focal signs, it is usually possible to make a fairly shrewd guess as to the location and the extent of the tumor. The mental symptoms accompanying tumor are usually irritability and childishness. Cases of tumor are frequently at first almost impossible to distinguish from beginning paresis.

Head injuries may also result in gross injuries to the brain; usually, however, such injuries are much less serious than would appear and the condition is one of traumatic neurosis. Sometimes there may be a real traumatic dementia, characterized by defects of memory and perhaps focal signs, such as aphasia. Such persons are usually exceedingly susceptible to the influence of alcohol. It should be said again, however, that real traumatic psychoses are very rare; some neurotic condition—neurasthenic or hysteric—is far more common.

Such cases as Dora P. (reported below) are comparatively rare. Her story is given here because the nature of the condition was so obvious, and because she illustrates very well the comparatively slight involvement of the personality usual in such cases—a circumstance to be contrasted with the profound alterations of personality which dominate the picture, in the functional psychoses.

Case No. 28

Name: Dora P. *Age*: 45. *Sex*: Female. Single. *Sources of information*: patient, an old friend of the family, hospital records of brother and sister.

I. History of the Family.

A. Medical—One brother insane with coarse brain lesions; this man has negative Wassermann and spinal fluid. A second

brother is tabetic. A sister is insane with the diagnosis of dementia præcox.

B. Social—Family seems to have been considered normal socially before the above-mentioned difficulties.

C. Educational—Family fairly well educated. All children finished high school.

D. Economic—One brother taught, one owned his store, and the sister was a private secretary.

II. History of the Individual.

A. Medical—Had always been well until recently.

B. Social—Normal until recently.

C. Educational—Normal school graduate.

D. Economic—Was a school teacher, and considered very good.

III. History of the Present Crisis.

A. Medical—Has been having headaches and nightmares. Complains of pressure of left side of head. Wakens with tired feeling and sore tongue—sometimes actually bites it. Has had two or three rather bad attacks of dizziness. Woke up in morning of day before entering hospital to find her left leg almost completely paralyzed. Has been forgetting things; and is disturbed by a buzzing in the ears.

B. Social—Has been rather seclusive and indifferent to things recently. Worries because she is developing symptoms such as her brother had.

C. Educational—Nothing.

D. Economic—Teaching has not been as good as usual because of tiredness and her obsessing fear of becoming insane.

IV. Present Condition.

A. Physical Condition—Well nourished—a bit too fat. X-ray shows a tumor down one side of brain. Paralysis of left leg and—since entering hospital—left arm and side. Negative Wassermann.

B. Appearance and Behavior—Appears normal. Facial expression suggests worry and fear.

C. Intellectual Condition.

General Level—Has I.Q. of 98 in spite of worry and physical condition.

Special Functional Disorders—Judgment—slight over-concentration on physical condition. Attention—normal. Memory—rather poor. Association—normal. Intake—buzzing in ears.

D. Emotional Condition.

Is worried and anxious about her condition, but hardly more dominated by worry than the situation calls for. Has long had a fear of going insane. Does not want to give up her work but is afraid she will become irresponsible and will

have to be sent away. Is considerably agitated at times over this possibility, but is hardly more upset than would be expected.

V. Summary and Conclusion.
  A. Summary—Bad heredity. Headaches and nightmares. Nocturnal seizures. Dizziness. Paralysis of left side. Forgetfulness; slight auditory hallucinations (buzzing in ears). Worry over condition. X-ray shows brain tumor.
  B. Conclusion—Coarse brain disease (brain tumor).

The Epilepsies

A few words remain to be said with regard to that strange group of episodic nervous and mental disorders, with related mental states, which are usually classed under "epilepsy." It should be made clear, in the first place, that "attacks" need by no means be epileptic in character, and that, further, epileptiform attacks may appear in a variety of conditions. "The epileptic," however, is a fairly distinct type of personality; and the "grand mal" attack is a classic form of mental disturbance. It is "the epileptic" rather than his attacks that it is important to study. However, it is the attack or "fit" which calls attention to the case. This attack may be of various types. When violent, the seizure consists of a convulsive attack, during which the patient falls to the floor and lies there jerking, and frothing at the mouth. This is called a "grand mal" attack. But many seizures are not nearly as violent. They may consist of apparent "fainting spells," periods of dizziness, or moments of unconsciousness, of so slight a nature that they frequently pass unnoticed.[1] Sometimes they occur altogether at night. Or the attack may be expressed in an "equivalent," such as an outburst of temper, a crying fit, a severe headache, or an automatic act. In fact, there is prob-

[1] It should not be inferred that all fainting spells or periods of dizziness are epileptic in nature! Such conditions are among the very most common experiences of physical malaise (practically everyone has gone through such episodes) and are usually due to nothing more than a stomach upset, fatigue, too much smoking, emotional shock. It is the more or less periodic affairs of this type, independent of such circumstances and usually associated with the epileptic temperament shortly to be described, that are suggestive of epilepsy.

ably a fairly continuous series from very light attacks, without any loss of consciousness, to "grand mal" attacks, followed perhaps by periods of confusion.

To the trained observer, the condition of the individual between attacks is hardly less indicative of the disease than the seizures themselves. A majority of epileptics have what is known as the "epileptic" temperament. The epileptic is likely to be irritable, quarrelsome, and ill-humored; he is unreliable; he is usually hypochondriacal; he is suspicious of everyone; he often displays a cheap religiosity. His opinions are likely to perform a right-about-face from day to day. Very often he becomes perfectly unreasonable about petty matters—he will buy a non-essential article for a dollar and then refuse his wife ten cents to buy bread. His ideas vary with his moods and, altogether, he is a most uncomfortable sort of person with whom to have daily relationships. Because of his temperamental difficulties he seldom has any friends and is always complaining about how "some people have all the luck." As the next attack approaches, these peculiarities of disposition become progressively worse; a man's family can almost always tell when an attack is imminent. As soon as the seizure is over, the individual feels better, his disposition improves for a short time, after which he again returns to his usual condition. The seizure may sometimes be followed by a fairly long period of bewilderment and confusion, during which the patient does not know what he is doing. During this period he is often very violent and has to be physically restrained, but sometimes he is fairly quiet and may go about unnoticed; he may, while he is in this dazed and dream-like condition, commit crimes of all sorts. After the individual recovers consciousness, he has no memory of what has occurred since the attack began.

Epilepsy is very likely to be associated with feeble-mindedness. The patient's family not infrequently includes feeble-minded members; it is, in fact, rather likely to be a somewhat degenerate family. If the history of the individual shows at-

tacks dating back into early childhood, there is very little hope that any treatment can result in a normal condition; usually those children who have had seizures from infancy are feeble-minded. It may be, however, that the attacks were either very infrequent during childhood or did not appear at all. As a general thing, there is a history of attacks of a distinctly epileptic nature in the history of the individual's life, or in the chain of circumstances that brought him to the notice of the investigator.

The patient's general character has been already indicated. The best single physical sign of epilepsy is the presence of scars on the face or tongue, indicating that the patient has injured himself in falling during his attacks. Scars on the tongue, plus a feeling of tiredness or soreness on awakening, are frequently the only symptoms of night attacks.

In general the prognosis is rather poor. Treatment consists largely in eliminating the proteids from the patient's diet and in keeping the bowels open; this alone will often materially cut down the number of attacks. Certain drugs are also used to control the frequency and severity of the seizures. It is sometimes helpful to remove a person to another occupation and environment because, while the disease is primarily physical, there are distinct psychical elements which further the attacks. The writers remember a boy—undoubtedly an epileptic—who had an attack every afternoon at 3 o'clock sharp! This afternoon seizure in every way resembled an attack; but he also had other attacks at irregular intervals. The affairs every afternoon were probably hysteric in origin, but were, nevertheless, very wearing on the boy. He was removed from his mother—who always called him in from play at about five minutes of three to have his fit—and he immediately improved without any other treatment.

The possibility of ever becoming entirely free from the disease is usually rather slight. In some people, in spite of all attempts to control the disease, there is a progressive mental deterioration, which may go on till the individual becomes entirely idiotic and demented.

It must not be supposed, however, that epilepsy always appears in subnormal individuals, that there is always a deterioration, or that there are always peculiarities of temperament.

Some epileptics are distinctly able individuals; there are many more such cases than the average person supposes because capable individuals are usually very careful to conceal the fact that they suffer from such attacks. Such individuals may show no evidences of deterioration whatever. One of the writers knew a very able college professor who, every eight or ten years, had a terrific series of "grand mal" attacks. In between times there was no evidence of any abnormality or deterioration. This person also showed nothing whatever in the way of epileptic moroseness—was one of the most popular members of the faculty. In fact, several of the epileptics whom the writers have known have been rather pleasant and good-natured than otherwise. As has been said so many times before, generalizations in psychiatry are risky, and should be applied only with great caution in individual cases.

The following two very different cases will make clearer the variety of personalities and episodes to be found among epileptics.

Case No. 29

Name: George T. (negro). *Age*: 26. *Sex*: Male. *Birthplace*: New York City. Married, two small children (4 and 6). *Sources of information*: patient's very matter-of-fact wife, two neighbors, school principal, police.

I. History of the Family.
   A. Medical—Family is syphilitic, alcoholic, and epileptic. Positive Wassermann for mother, wife, and one child. Father and mother epileptic. All the men alcoholic.
   B. Social—Family always in depths of poverty. Not liked in neighborhood.
   C. Educational—Father could barely read; mother illiterate.
   D. Economic—No steady occupation for any one. Day laborers.

II. History of the Individual.
   A. Medical—Has had epileptic seizures from childhood—usually of the "grand mal" type. Is alcoholic—which increases his susceptibility to attacks. Always constipated.
   B. Social—Is intensely religious—without letting his religion interfere with his "business"—and attends revivals constantly. Becomes excited and somewhat confused. Has been "converted" a dozen or more times; enjoys the emotional experience. Has a very bad temper and occasionally abuses his children during an outburst of temper. Is irritable and irresponsible. Occasionally leaves his family for a week or two.

C. Educational—About fifth grade in school.
D. Economic—Is a day laborer, employed very irregularly and usually fired soon for laziness and ill-temper.

III. History of the Present Crisis.
A. Medical—Had a series of "grand mal" attacks, covering a period of two to three hours. Has since then been confused and delirious. Is completely oblivious to his surroundings. Is in a state of "furor."
B. Social—Was at a revival meeting. Suddenly he called out that he had "seen the light" and fell down, groveling on the floor. The audience—mostly colored—thought him inspired. For over two hours he remained on the floor alternately having "jerking spells" and yelling out the latest news of his conversion. During his silences he was thought to be "getting messages" and the jerking was attributed to the leave-taking of the "Demon Rum" (the man had been drinking)—supposedly the "devil" was being driven out of him. In between spasms, he shrieked out exhortations, sang psalms, prayed and wept. The congregation joined in, praying aloud and singing. This continued for over two hours. Then the emotional fervor of the congregation began to flicker out, but the patient continued more and more furiously, yelling, "I'se in de arms o' de Lawd!" etc. It is a curious comment upon the nature of the revival services that this man was doubtless in a delirium for over two hours and no one realized it. Finally, the police heard the wild screamings, interrupted the meeting and—realizing that the man was insane—sent him to a hospital.
C. Educational—Nothing.
D. Economic—About as usual until beginning of attack.

IV. Present Condition.
A. Physical—Good physique and general health. Positive Wassermann. "Grand mal" seizures followed by period of confusion and delirium.
B. Appearance and Behavior—Thrashes around on bed. Has to be "cold-packed" a good deal of the time. Yells and screams. When not restrained, he frequently kneels in bed and alternately stretches his arms over his head and prostrates himself, chanting and praying. Takes no notice of anyone.
C. Intellectual Condition.
General Level—Impossible to test; probably very low.
Special Functional Disorders—Judgment—is completely disoriented. Delirious. Attention impossible to attract. Memory can't be tested. Association—completely discon-

nected. A good deal of his talk consists of religious ejaculations. Intake—impossible to judge.
D. Emotional Condition—Tremendously overexcited.

V. Summary and Conclusion.
A. Summary—Bad heredity. History of epileptic seizures. Syphilis and alcoholism. Irritable and irresponsible. Can't get on with any one. Irregular employment. Outbursts of temper; cruelty to children. Now epileptic furor: Complete confusion and disorientation, delirium, religious excitement, overactivity, and violence.
B. Conclusion—Epilepsy. (Epileptic Insanity.)

CASE NO. 30

Name: Willis D. *Age*: 14. *Sex*: Male. *Birthplace*: New York, Single. *Sources of information*: parents, school principal and sixth-grade teacher, officials in institution.

I. History of the Family.
A. Medical—One uncle is said to have had some kind of "fits." Father slightly alcoholic.
B. Social—An older brother was brought before the juvenile court for general incorrigibility. Has been in reform school, but seems to be much less of a problem now; has been out on parole for two years. Otherwise the family seems harmonious and happy.
C. Educational—Father left school in seventh grade, mother in sixth. Older brother finished eighth grade in reform school. Younger brother and sister doing well in elementary school.
D. Economic—Father is a plasterer; earns good wages.

II. History of the Individual.
A. Medical—During infancy and early childhood the boy had "tantrums" and outbursts of anger upon very slight provocation. He would fall on the floor and kick and scream. Mother never noticed any loss of consciousness. Since about six years of age has had what were evidently "petit mal" attacks, from the mother's description of a period of some dizziness, a few tremors, and momentary loss of consciousness. Very rarely falls during these attacks.
B. Social—Boy is usually good-natured and friendly, but occasionally becomes irritable and excited. These periods do not seem related to the attacks just mentioned. (They might be an equivalent?) Has many friends and is quite popular with them.
C. Educational—Boy is now in sixth grade in an institution for epileptics. He started school at 6 years and was promoted regularly until he reached the 5a grade where he was re-

tarded for a half year. He has been in the sixth grade nearly two years now and seems unable to learn. Marks were very good during the first two grades, but have become increasingly poorer.

D. Economic—Nothing.

III. History of the Present Crisis.

A. Medical—Attacks have become somewhat more frequent during the last year until now he has 5-6 sometimes in a single day, although he usually averages about 10-12 a week. It is hard to tell just how many he has as they are so light as to frequently escape notice.

B. Social—Has been obviously duller and less alert, but there seems to have been no real character change. He is still irritable occasionally, but not often.

C. Educational—His work became so poor and he was progressing so little in school that he was sent to the school clinic for examination. His teacher said he was learning nothing. On the basis of the findings he was sent to an institution where he is doing a little better.

D. Economic—Nothing.

IV. Present Condition.

A. Physical Condition.
General Condition—A rather poorly developed boy, a little underweight (6 lbs.). Some scars on tongue.
Special Defects—None.

B. Appearance and Behavior—Well-appearing, well-mannered boy; nothing unusual.

C. Intellectual Condition.
General Level—Boy earns an I.Q. of 74. He was tested a few years ago in school by an inexperienced social worker and received an I.Q. of 94.
Special Functional Disorders—A very poor memory, but no other obvious difficulty.

D. Emotional Condition.
General Emotional Tone—Usually good, but with short periods of irritability.
Special Emotional Trends—None evident.
Emotional Conflicts—None evident.

V. Summary and Conclusions.

A. Summary—One incorrigible member of family, history of "petit mal" attacks, periods of irritability and excitement, failure in school work, gradual mental deterioration.

B. Conclusion—Epilepsy.[1]

[1] This boy showed attacks all very much like each other. He would become momentarily unconscious, stand motionless for a moment, walk straight forward for 5 to 8 yards, give a little start, grin rather sheep-

Abnormal Conditions Associated with Certain Physical Diseases

The conditions covered so far have been abnormal mental states associated with disease confined primarily to the central nervous system. Certain well-known physical diseases, however, not uncommonly have mental correlates or a special emotional expression. Thus diabetes frequently causes depression and irritability with more or less melancholy delusions. Cardiac troubles are usually accompanied by a state of extreme anxiety; tubercular patients may show surprising cheerfulness—in fact be distinctly euphoric. On the other hand a person with stomach trouble, or other digestive difficulty, is pretty sure to be distinctly irritable, depressed, pessimistic, hypochondriacal. In fact, hardly any person is quite the same temperamentally when sick as when well. This must always be remembered in dealing with any case.

In connection with certain physical conditions an acute psychotic condition may develop for a brief period. Such are the *infection* and *exhaustion psychoses*. Such conditions may develop in connection with typhoid fever, typhus, with influenza or pneumonia, with conditions of physical strain such as childbirth. The condition is due either to infection or to exhaustion after a long period of acute illness.

The psychosis consists largely of a general delirious condition. The sick person becomes confused and dreamy and does not recognize the people around him. His ideas seem to flow on of their own accord without any logical sequence. He has vague, indefinite hallucinations. Sometimes the emotional tone is depressed and irritable; sometimes it is somewhat excited. In either case, there are likely to be many restless, impulsive, meaningless movements and a considerable amount of twisting and turning about. It is, roughly, the usual picture of a person with a high temperature.

ishly and then go right on with whatever he had been doing; rarely he would fall just before regaining consciousness. The entire attack usually did not occupy as much as 30 seconds.

In such psychoses the family history is usually of slight importance. The previous history of the individual, however, may often be worth close study. Individuals in whom resistance to fever is very low will usually be found generally unstable; the person who develops a delirium on one or two degrees of temperature is probably psychopathic. Some emotional difficulty may be an important factor in the situation; for instance, illegitimate pregnancies are most likely to cause mental trouble. However, the physical disease is the outstanding feature of the situation. And the history of the present crisis is largely a history of the development and the course of the disease. The prognosis is usually good; if the patient lives at all, the mental symptoms will disappear.

The following two cases will serve as illustrations of conditions of these types.

CASE NO. 31

Name: Flora D. *Age*: 26. *Sex*: Female. *Birthplace*: Massachusetts. Married. *Sources of information*: husband, obstetrician.

I. History of the Family.
   A. Medical—Nothing known, except that husband has venereal disease.
   B. Social—Nothing abnormal known. Little information to be had.
   C. Educational—Nothing known, except that about grammar school education.
   D. Economic—Nothing known, except that father a farmer.

II. History of the Individual.
   A. Medical—Normal so far as known—fair health up to present illness.
   B. Social—Normal social relationships apparently.
   C. Educational—Finished grade school.
   D. Economic—Worked as clerk before marriage.

III. History of the Present Crisis.
   A. Medical—Had child after very hard and prolonged labor a week before admission to hospital. Has gonorrheal infection. Developed high temperature and delirium.
   B. Social—Nothing.
   C. Educational—Nothing.
   D. Economic—Nothing.

IV. Present Condition.
A. Physical Condition—Completely exhausted from childbirth and infection. Has gonorrhea. Temperature 105°.
B. Appearance and Behavior—Throws herself about on the bed. Stretches and twists. Moans and cries. Occasionally reacts to a hallucination by a shriek. Is never still; rolls and tosses about. Sometimes tries to rise and has to be held back. Mutters incoherently.
C Intellectual Condition.
General Level—Apparently about average—impossible to determine at present.
Special Functional Disorders—Judgment—completely disorganized and delirious. Attention—impossible to attract. Memory impossible to determine. Association—entirely wild and bizarre. Intake—has some fleeting visual hallucinations.
D. Emotional Condition.
General Emotional Tone—Overexcited, almost a frenzy, at times.
Fearful; seems dominated by fear.

V. Summary and Conclusion.
A. Summary—Fever and delirium. Recent childbirth. Exhausted condition. Gonorrheal infection. Delirium with accompanying restlessness and moaning. Some hallucinations.
B. Conclusion—Infection Psychosis.

CASE No. 32

Name: Vera M. *Age*: 26. *Sex*: Female. *Birthplace*: Ohio. Single. *Sources of information*: parents, friends, family doctor, nurse.

I. History of the Family.
A. Medical—Nothing of importance.
B. Social—Family rather prominent in the small city where they live.
C. Educational—Fairly well educated—both parents high school graduates.
D. Economic—Rather well-to-do people; father a contractor and builder.

II. History of the Individual.
A. Medical—Normal until recently, but rather frail and "nervous."
B. Social—Has always been somewhat excitable and flighty. Is troubled with insomnia after any social event, she becomes so excited.
C. Educational—High school graduate.
D. Economic—Has been a "society girl" since graduation.

III. History of the Present Crisis.
  A. Medical—Has been seriously ill for about three weeks with influenza. Is better of the disease now, but has not entirely recovered.
  B. Social—Has been delirious part of the time, and very irritable and complaining, and hard to take care of.
  C. Educational—Nothing.
  D. Economic—Has, of course, been doing nothing because of illness.

IV. Present Condition.
  A. Physical Condition—Very thin and white, except for flushed cheeks. About one degree of temperature. Pulse weak. Prostrated and exhausted.
  B. Appearance and Behavior—Some of the time she lies quietly in bed, in a sort of stupor. When aroused for any purpose, she protests and wants to be left alone, but is so weak that she soon does as is desired. Sometimes she makes weak, meaningless movements, twists from side to side, etc. Talks considerably in a thin, querulous voice.
  C. Intellectual Condition.
    General Level—Apparently average.
    Special Functional Disorders—Judgment—considerable disorganization. No real delusions as patient is too disorganized to have them; but she mistakes the identity of those about her. Is disoriented. Attention—flighty and distractible. Memory—appears to be gone, but can't be really tested because of poor attention and exhaustion, due to the disease. Association—almost no logical association. Patient seems to be in a sort of dreamy state in which her ideas flow along, with more or less connection, without any apparent volition on her part. Intake—has a few vague, visual hallucinations, but doesn't pay much attention to them.
  D. Emotional Condition—Apathetic. Is childish, seems dazed and confused. Very irritable in a weak sort of way.

V. Summary and Conclusion.
  A. Summary—Recent severe influenza and high temperature and delirium. At present, state of exhaustion. Is still very sick. Has always been excitable. Is confused and dazed. Somewhat irritable. Some vague delusions and hallucinations. Little connection between ideas. Is stuporous some of the time; at other times, moves about in bed restlessly.
  B. Conclusion—Exhaustion Psychosis.

Certain extraordinary mental conditions, associated with disorders of the ductless glands, remain for brief mention. The conditions are, comparatively, rare; but they are so striking,

and so suggestive of possible explanations for other obscure mental conditions, that they well deserve brief description.

Any disorder of the thyroid gland, in particular, is certain to be associated with a fairly definite mental picture. Undersecretion of the gland is accompanied by a slow association of ideas and impaired retention, perhaps some emotional depression or lethargy, and slowness of movement as well as of thought. With these mental symptoms goes a characteristic and extraordinary physical state, characterized particularly by an edematous condition. On the other hand, hypersecretion of the gland—exophthalmic goiter—is accompanied by apprehension, restlessness, and insomnia, with perhaps some vague hallucinations; and physically there are again profound changes, with loss of flesh.

Moreover, disease of the thyroid gland beginning in childhood brings about a characteristic and extraordinary state of feeble-mindedness. There is a peculiar silly sort of mental incapacity which may be of extreme degree. And even more astounding is the peculiarly stunted and malformed physique, with thick skin, coarse, puffy features, and strange, harsh voice. The condition is known as cretinism.

The following case is more or less typical, in its complications, of many cases of the types above mentioned.

CASE NO. 33

Name: Zurma A. *Age*: 24. *Sex*: Female. Single. *Sources of information*: patient, father, a neighbor, the family doctor.

I. History of the Family.
   A. Medical—Normal.
   B. Social—Normal.
   C. Educational—Father is a graduate of a southern agricultural school and the mother was in a university for two years. Brother was in college for one year.
   D. Economic—Father was wealthy farmer.

II. History of the Individual.
   A. Medical—Has a goiter. Has severe headaches and is very depressed and worried.
   B. Social—Seemed perfectly normal until two years ago. At that time her brother was permanently injured. Through

a feeling of duty she dropped all activities and has become his nurse and companion. She was never very talkative but her brother wants her to keep still practically all the time, so she hardly ever speaks. She worries constantly about both herself and her brother.

C. Educational—Finished eighth grade.

D. Economic—Has never done any work outside of the home.

III. History of the Present Crisis.

A. Medical—Exophthalmic goiter.

B. Social—Has been very apprehensive of late. Has been "acting queer," has had spells of crying, short periods of depression, evidences of agitation; considerable talk about her condition to any one who will listen, etc.

C. Educational—Nothing.

D. Economic—Nothing.

IV. Present Condition.

A. Physical Condition—Goiter, severe headaches, extremely sallow complexion, bulging eyes, lusterless hair.

B. Appearance and Behavior—Sits staring idly in front of her most of the time with a worried expression. Occasionally walks about restlessly. Talks in a complaining, whining voice.

C. Intellectual Condition.

General Level—Has I.Q. of 87, which is probably to be considered too low, owing to her condition.

Special Functional Disorders—Judgment—mind centered on physical condition of herself and her brother. Attention very poor for other matters. Memory apparently about normal. Association—some retardation. Intake—normal.

D. Emotional Condition.

General Emotional Tone—Some depression, but more often seems apathetic.

Special Emotional Trends—Is very worried.

Emotional Conflicts—There seems to have been some conflict about giving her own life to her brother's needs, especially as he is very unreasonable. At present her own physical condition is occupying her attention and she is willing to remain at home, but feels she should receive some of the attention given her brother.

V. Summary and Conclusion.

A. Summary—Goiter, headaches, sallowness, bulging eyes. Devotion to brother, lack of any social life, abnormal home-life. Depression, occasional agitation, worry, apathy.

B. Conclusion—Mental condition accompanying goiter, with psychogenetic complications.

Disorders of the other ductless glands are accompanied by other more obscure, but no less striking symptoms, physical and mental. Such conditions are interesting in themselves; they are also well worth consideration as suggesting that such disorders of the internal secretions may well play a part in other mental conditions, with which they have not yet been explicitly associated. For instance, it is quite possible that the internal secretions of the sex glands may play an important part in causing, or at least in developing, the peculiar conditions of dementia præcox. 153 – 147

So much, then, with regard to the various conditions which have been grouped, very roughly indeed, under the general head of the organic psychoses. First was considered (1) *general paresis,* a dementing psychosis now known to be caused by syphilis. Then were discussed (2) the *toxic psychoses,* especially the conditions due to alcohol, and following this (3) the *senile psychoses,* and (4) the psychoses due to *gross brain disease.* Following this was a brief discussion of (5) *epilepsy.* Finally, were mentioned (6) certain mental conditions largely incidental to the course of diseases primarily physical. The conditions described have been most varied in character. However, the reader has perhaps come to appreciate the difference between these conditions, which somehow seem to come upon the personality from without, and the conditions described in the previous chapter which seem to have a more integral relation to the personality. The distinction is not always of great importance. But at least (as will appear shortly) the problems of prevention and hygiene are very different for the two types of psychotic condition.

CHAPTER X

THE FEEBLE-MINDED

What Is Feeble-mindedness?

In the two previous chapters, dealing with mental diseases, a variety of conditions has been presented, due to a great variety of causes, but showing mental symptoms so shading into each other that the beginner often sees no essential differences between the mental diseases as far as the mental condition is concerned; in actual dealing with individual cases he may rather feel that each case is different from every other.

The situation is hardly less confused as regards conditions of mental deficiency. Really, instead of speaking of feeble-mindedness we might better speak of the "feeble-mindednesses." There are really a great variety of conditions of amentia, or initial lack of mentality, due to a great variety of causes; one might almost say that there were as many kinds of feeble-mindedness as there were kinds of mental disease. Moreover, the situation is further complicated by the fact that a feeble-minded person may also suffer from a psychosis, to which statement is to be added the fact already mentioned that mental disease may bring about a dementia which might be called an acquired feeble-mindedness! Finally, it must be mentioned that a person may (as was emphasized in the first chapter) be very stupid indeed and still have a distinct character of his own. The "tenderfoot" worker, venturing for the first time into the study of mental defectives, often has the notion that the feeble-minded can be regarded, somehow, in much the same impersonal and general way that one would study a physical specimen in the laboratory. Such an investi-

gator (unless suffering from a truly extraordinary lack of sensitivity to facts) is soon brought up with a start to the realization that even the "feebs" may have ideas of their own, and their own desires and self-respect; they may have very definite personalities and be right vigorous in the assertion of them.

One must not, then, get into the habit of generalizing easily about "the feeble-minded." However, for practical purposes, certain general distinctions of great value can be made. And for many practical purposes these general classifications are quite sufficient. In the first place, by definition the term "feeble-minded" is applied to those individuals who are markedly lacking in mental capacity as a result of *incomplete mental development;* individuals suffering from mental enfeeblement *resulting from mental disease* are not included in this classification. These last cases are dements. The demented person is a person who has lost a certain amount of the ability which he earlier had; the feeble-minded person has simply never had any fair stock of ability to lose. This distinction between the aments and the dements—between the mentally undeveloped and the mentally invalid—is of first importance.[1]

It must also be understood that the notion of "mental symptoms" must be greatly broadened, if we are to have a symptomatology of feeble-mindedness for the higher grades of mental defect. An hallucination or a delusion is a fairly discrete bit of fact which may be used as evidence of mental disease; so are the tremors of the alcoholic and the pupillary anomalies of the general paretic. Extreme cases of feeble-mindedness (the idiots and imbeciles) also show such definite symptoms; there are gross physical deformities, gross defects in speech or lack of speech, and various neurological symptoms. However,

[1] It must be repeated, however, that a feeble-minded individual may have a mental disease—and dementia. Mental disease is, as a matter of fact, very common in the feeble-minded. (See, for instance, Tredgold, H. F., *Mental Deficiency* (4th edition, 1922), p. 347 ff.) Further, certain static conditions of dementia are, from a practical point of view, almost indistinguishable from amentia. Like so many psychiatric distinctions, the concept is of little use in the study of many actual cases.

the concept of feeble-mindedness has been extended to various obscure conditions characterized primarily by social and economic incapacity. This extension has proven very suggestive as an explanatory method in study of various social problems. As a natural result, the concept has been abused, and there is much loose talk tending to the supposition that chronic social and economic maladjustment and feeble-mindedness are synonymous.[1] Psychiatrists, sociologists, and psychologists have all sinned in this way. There is a curious tendency to absolve the social organization completely from blame for the failure of any person to adjust to its system; and the burden of social responsibility has been very deftly shifted, so that efforts at social betterment have been superseded by ineffective eugenical theories. Under such circumstances it is essential that underlying principles be carefully defined, and that the criteria for diagnosis be as explicitly stated as possible. Hence the relatively detailed discussion in the following sections.

The Classification of the Feeble-minded

It has been suggested above that there are a great many different types of feeble-mindedness, and a great variety of conditions which may operate to bring about an arrested mental development. However, from a practical point of view, rough general classifications of the feeble-minded according to the degree of mental disability may be made. Three grades of feeble-mindedness may be thus distinguished: (1) the idiots, (2) the imbeciles, and (3) the morons.[2] The differences implied in the classification are essentially differences in degree of subnormality.

[1] For recent work on the relation between intelligence and delinquency see Rosanow, Curt, "Is Lack of Intelligence the Chief Cause of Delinquency?" *Psychological Review*, Vol. 28, pp. 147-57, 1920; Doll, E. A., "The Comparative Intelligence of Prisoners," *Journal of Criminal Law and Criminology*, Vol. 11, pp. 191-97, 1920, and Murchison, Carl. "American White Criminal Intelligence," same journal, Vol. 15, pp. 239-316, 1924.

[2] Some authorities mention, in addition, a borderland group of the "constitutional psychopathic inferior." The "constitutionally inferior"

(1) Idiots are usually defined as individuals who are so lacking in intelligence that they cannot even live without constant attention and care. Some have to be fed, as they would starve with food lying beside them. Many do not learn to attend to the calls of nature and must be looked after like babies. Some never even learn to sit up, but remain in bed throughout their lives. They never learn to talk. They are almost entirely unteachable; many never learn to anticipate a movement of the bowels far enough ahead to let an attendant know of it. In general, idiots are unable to care for themselves and would soon die if not taken care of. Some idiots are stolid and completely apathetic, but others are noisy and boisterous and have terrific outbursts of temper during which they scream and tear everything to pieces—bedclothes, clothing, etc. In general, an idiot never develops in intelligence beyond the level of a normal child two years of age, and must always be treated as a baby.

(2) Imbeciles present a little more cheerful picture. They are capable of talking and walking and of learning some few simple tasks—such as dusting, mopping floors, ironing flat pieces, or peeling potatoes. But even such simple work will not be performed unless the imbecile is closely supervised. He thus has capabilities so slight as to be almost worthless economically; he cannot earn a living in the ordinary environment. Socially the imbecile shows an inability to grasp the usual rules of conduct. Such cases have practically no inhibitions and are unable to judge or appraise their own conduct. Adult imbeciles have mentalities ranging from about three to seven years in mental age.

(3) A moron is usually defined as a person who is capable of learning to read and write and who can do simple work; the

are largely normal in intelligence but are rather characterologically inadequate. Physically, the individual is undersized, puny and weak-appearing; he seems to be very lacking in general energy and vitality. Emotionally, he is a little apathetic or indifferent and seems childish and incapable of any really deep emotion; he has no will-power and seems wholly lacking in what is usually called "backbone." There is lacking, also, maturity of judgment and moral discrimination, and ability to do independent thinking. There is the general impression of a spineless, purposeless, childish, undeveloped personality, with a general inferiority in every field. The individual is likely to show an overdevotion to detail because he lacks the intelligence to grasp anything more comprehensive. Very frequently he is fussy, petty, complaining, wholly unable to assert himself. He is, indeed, in every sense of the word, a "little" man.

moron is, however, incapable of working efficiently except under supervision, cannot look after his own affairs "with ordinary prudence," is incapable of consistent planning, and is often lacking in appreciation of moral sentiments, lacking in judgment, and poorly inhibited. The moron class thus provides many of the petty thieves, "toughs," drunkards, prostitutes. These morons are often the tools for those more intelligent than they. They are usually readily detected in criminal acts and so appear to make up a rather greater proportion of the criminal world than they actually do. Adult morons have mentalities ranging from seven to about ten years.

It must not be supposed that these three types are distinct from one another; they are not. But it is convenient to speak of those cases showing a mentality roughly analogous to that of children under two years as idiots; they are unable to take care of themselves, to talk, to guard themselves from common physical danger. The imbecile may be compared to a child between the ages of three and seven. He can talk but can seldom learn to read or write. The moron may be thought of as mentally somewhat similar to a child between the ages of seven and ten. He can acquire the minimum of schooling, but is essentially irresponsible.[1]

Such mental-age classification is exceedingly convenient—and so exceedingly likely to mislead, and prevent thorough consideration of fundamental hypotheses. The feeble-minded are problems just *because* they differ in most respects from children. The adult moron is different physically, in the first place, from a child eight or nine years old. He is a hulking man with all the capacity for criminal acts that this implies. He is different from the child emotionally and (most important of all) sexually. Further, it is extremely doubtful if we can think of his mental make-up as similar, in any except a very general way, to the child mind. But with all these reservations, which are very necessary because they are not often made, we may tentatively express our degrees of mental enfeeblement in terms of years of mental growth.

[1] Illustrative case studies will be found at the end of this chapter.

The Type Case

The family histories of feeble-minded persons are likely to be rather similar whatever the degree or nature of the feeble-mindedness may be. Frequently, one or both the parents are also feeble-minded. In fact, most of these cases fail to develop because their progenitors were possessed of subnormal intelligence; it is estimated that about sixty per cent of feeble-mindedness is directly inherited. Because of this strong hereditary feature, an adequate family history is a great help in the diagnosis (though one must be on his guard not to diagnose a case by his family). Other special features are usually found in the history of the family. The most prominent of these are alcoholism, syphilis, deaf-mutism, insanity, and epilepsy.

The history of the individual is likely to run something as follows: The child probably walked late, talked late and very likely had speech defects; he wet the bed until ten or twelve years of age and perhaps soiled his day clothes as well. He entered school late and then failed of promotion in practically every grade. He never played with children of his own age. He never learned to help in the tasks of the household. Learning to read and to do arithmetic was particularly difficult and, unless the child is in the moron class, such ability to handle symbols was probably never acquired. Feeble-minded children are likely to have had convulsions at some time. As they grow older, they often become involved in delinquencies.

Usually this is not due to any essential viciousness. The trouble is simply that the individual is not able to meet the complexities of life, and so drifts into thieving and other petty criminality or into prostitution; usually he is the tool of some more intelligent person. The feeble-minded are capable of adjustment to only the simplest sort of environment, and are usually incapable of earning a living, unless at the very simplest tasks. So they may be turned into delinquency by economic inefficiency, or they may blunder into difficulty from lack of understanding to keep out.

However, there may sometimes be a special lack of emotional control, or a positive viciousness. Delinquency is then the prime symptom. Such cases chronically steal, tell falsehoods, perhaps are wantonly cruel, bully other children. They have early sex experiences. They play truant, live on the streets, run away from home and stay out nights, become vagrants. Very frequently they appear in juvenile court as "incorrigible."

Such is the typical early history of a feeble-minded case. There is a continuing inadequacy, of which the evidence is cumulative. The deficiency may be somewhat obscured by a very agreeable or altogether passive personality. Under such circumstances, a teacher may develop a certain fondness for the youngster because he is obliging, presents no disciplinary problems, and in comparison with the younger children, with whom he is usually placed, does not appear as dull as he is. But after a while the backwardness in school becomes too marked to be blinked at any more; the case has to be faced as educationally inadequate, and probably leaves school as soon as the legal age is reached though still in only the fourth or fifth grade. If the school has a "progressive" attitude toward retardation, he may go further. Then after leaving school the economic world finds him out. If the "feeb" is a girl, she may dodge her economic inadequacy by prostitution, or solve the economic problem on a slightly different sex basis by marriage. But sooner or later a crisis is likely to make the incapacity plain.

In some cases, of course, the feeble-mindedness is acquired, and the cause appears in the history of the individual. In these few cases, the important feature in the history is an accident or a severe illness. A frequent cause—not hereditary—is the use of instruments at birth; sometimes the child's head is so injured as to render him incapable of development; such cases are usually idiots. Occasionally, some disease arrests the mental development. Meningitis and hydrocephalus are the two most common of such diseases; these children, too, are usually of very low-grade intelligence. Congenital syphilitics are almost invariably feeble-minded. Because of these

accidents or diseases, feeble-minded children are sometimes found in excellent families, where there is no hereditary taint. In such cases the cause of the subnormality usually thus appears in the history of the individual.

The present crisis usually comes about either through conduct difficulties (chronic delinquency) or through unmistakable inability to learn in school. Sometimes, however, the case comes into contact with the authorities through the merest accident. Thus the writers knew of a colored imbecile in his twenties who had never been recognized as feeble-minded until "run in" by a sensitive-minded policeman for making faces at him. Investigation showed the "boy" to have a mental age of under four years, though some six feet tall.

It should be further understood, however, that with the feeble-minded there is no crisis in the sense in which this word has been used in the two previous sections. The study of the present crisis has meant, in the consideration of the psychoses, the study of the initiation and development of the disease process. With the feeble-minded there is nothing of this sort. The crisis is not psychiatric, but social or economic. One might almost say that the problem was to keep the diagnosis from being altogether social.

The case, as seen by the clinical psychologist, social worker, or personnel manager, may seem at first to present little that is definite in the way of concrete evidence upon which to base a diagnosis. Of course, the obviousness of the case depends upon the degree of the mental deficiency. Some general characteristics can, however, be given. Physically, there is often a very labored awkwardness and incoördination in gait and in other movements; there is no grace or spontaneity of movement. The features are often asymmetrical. Various special defects—the stigmata of degeneracy—are very likely to be found, such as V-shaped palate, malformed palate, crooked or notched teeth, protruding ears, strabismus or other eye-trouble, harelip, malformed head, etc. Speech is especially likely to be defective.

Emotionally, the most persistent impression is of a rather apathetic, indifferent, listless temperament, with no vivacity and a lack of any of the finer sentiments or social feelings. However, there may be a certain surliness—which suggests a defense reaction against teasing from acquaintances who took advantage of the individual's stupidity. There may be a great loquacity, a regular deluge of talk of an exceedingly shallow and repetitious variety; or, there may be a monosyllabic vicious ugliness of mood—particularly where there is a suggestion of epilepsy. The lack of emotional sensitivity may display itself in most striking fashion in a great vulgarity and in a rather silly sex susceptibility.

Mentally there is feeble-mindedness! No capacity is developed as well as it should be. The individual's mentality is loosely organized; his system of beliefs and judgments is poorly developed; memory is poor; and there is little capacity for learning. Flow of ideas is slow. There is little or nothing in the way of sensory disorders—nothing in the way of active psychotic symptoms, such as hallucinations—only a general blunting, perhaps, which is of negligible importance.

Appearance and behavior are—stupid. The clumsiness already mentioned, with slovenly, indistinct speech, a heavy face with no expression, and ill-fitting and slovenly clothes on an awkward and poorly proportioned body, are all characteristics.

The Diagnosis of Feeble-mindedness

Well—the diagnosis may sound easy enough. But there are a great many people who are lacking the finer feelings, who are intellectually not over-bright, and who are both clumsy and ill-dressed. It is also both a scientific fact and a matter of observation that "the feeble-minded" are not a group off by themselves, but simply the extreme lower end of the total distribution of ability. So diagnosing the case as feeble-minded is not like detecting a disease. It is rather a matter of deciding whether a particular individual comes up to a certain rough standard, which is considered to be necessary for

those who shall be allowed to run their own affairs in the world and be expected to keep themselves out of trouble.

The writers are, of course, speaking particularly of the borderland cases, the morons. Idiots are almost invariably, imbeciles usually, early recognized as such by the family physician and dealt with for what they are (at least this is the case where the feeble-minded will be given any special attention anyhow). The problem of diagnosis appears in those cases which are mild enough so that they are not recognized until they begin to make trouble. When the experienced clinical psychologist or social worker thinks of the feeble-minded, the thought is not usually of the idiots or imbeciles at all; it is of the morons. The idiots are not a problem; they are simply a burden.

Diagnosis must then be recognized as very largely a matter of expert judgment, based on the facts in their totality rather than on any particular set of symptoms. The feeble-minded are different in degree, not in kind, from the average individual. However, the individual making the diagnosis must not let himself decide the case on the basis of his impression rather than his judgment, simply because he cannot be expected to point out any stigmata, physical or mental, *pathognomonic* of certifiable mental deficiency. The diagnosis should be based on a carefully ordered array of facts. There should be (1) obvious inadequacy in school; most of the feeble-minded do not get beyond the fifth grade; the feeble-minded child is usually two, three, or more years over age for his grade. (2) In the adult there should be clear evidence of economic inefficiency, as shown in the elementary type of work done, in frequent change of job, and in unemployment. (3) In both children and adults it is to be expected that there will be continuing evidence of social inadequacy. The child does not play normally with children of his own age; and he is likely to be the butt of jokes or viewed with a good-natured tolerance, but in any case judged with surprising accuracy by other children. As an adult the individual does not mix as an equal

with others of his natural group. There may or may not be delinquency, but there is always the evidence of inferiority. (4) Careful trial of the individual with certain simple problems, as of practical arithmetic, judgment with regard to problems of conduct, small exercises of ingenuity, for which standards have been determined (for the purpose primarily of studying just such cases), should show the individual to be markedly below average in ability to do such simple tasks. That is, the individual should be given some "intelligence tests." And, if he is an adult and is to be diagnosed as feeble-minded, his mental age should be no higher than ten; the cautious clinician will hesitate to make a diagnosis of "f. m." unless the mental age is nine or below.[1] These four sets of facts, (1) educational inadequacy, (2) economic inefficiency, and (3) social inadequacy, and (4) a distinctively low rating in a carefully conducted series of tests, are essential for a satisfactory diagnosis.

Some qualifications remain, however, with reference to each one of these factors.

In the first place, schools and school systems vary markedly in their promotion policies. A school may refuse to keep a child in one grade more than two years. If this policy is combined with low standards and the child is of the inoffensive sort, an undoubted "feeb" may graduate from grammar school. Investigators are often careless and undiscriminating in their use of the school history.

In the second place, economic inefficiency is, like everything else, subject to the law of relativity; economic requirements are much higher in some places than in others, and at certain periods. One of the writers knew of a syphilitic Italian imbecile who was making a dollar a day, in the early part of the war, picking rubbish out of rags. Defective individuals

[1] In work with children an I.Q. below 50 may be considered suggestive of imbecility; and in general any case with an I.Q. definitely below 70 deserves further study as a possible defective. The diagnosis is made on the basis of points 1, 3, and 4 after roughly the same methods as in study of adults. . . . Further discussion of this troublesome topic will be found in the chapter on Differential Diagnosis, and in the references at the end of this section of the book.

very often get along well enough in the Kentucky mountains, but become a nuisance, progressively more noticeable, the further up into Indiana they emigrate.

In the third place, what has been called social inadequacy may not be apparent at first glance. Physical size and strength, or physical attractiveness, great good nature, or an affectionate disposition, various special circumstances such as wealth or the position of the family, may operate to obscure the situation. However, intimate study of the situation almost invariably shows the inadequacy to be recognized by associates.

Finally, a test is not a method which relieves one of the necessity of thinking about a case, but should function as an aid to more careful study. The results of the test must be carefully judged, in the light of all other information. The examiner should be expected to form a judgment of the reliability of the test findings. Thus if a case is extremely uncooperative, speaks English only slightly, or for other reasons fails to do himself justice on the test, these facts must be noted.

If, in addition to the four sets of facts above mentioned, there is a suggestive family history and a history of delinquency, so much the better. But neither delinquency nor a rotten family should be alone sufficient to commit one to a state institution for the feeble-minded—though the writers have known such things to happen. They occur with conscious appreciation of the anomaly, sometimes, because an institution for the feeble-minded is the only place available for segregation of a case that unmistakably needs segregation. But if the term "feeble-minded" is to have the definiteness of meaning which it should have, delinquency and deficiency must not be confused. They are not the same thing, they are often brought about by different causes, they frequently (a most important point) require different treatment.

Treatment and Care of the Mentally Inadequate

And now a word about the treatment.[1] / Feeble-mindedness cannot be "cured."/ There is no medical treatment for such

[1] Further material bearing on treatment will be found in the chapter on Mental Hygiene.

responsibility should stop with the feeble-minded. . . . The possibilities of the situation are extremely interesting. The topic will be returned to in Chapters XIV and XV.

A word remains to be said as to what can be done, and is usually done, in an institution and under outside supervision, for the mentally defective. In an institution with the low-grade morons or imbeciles, the training usually starts with sense perception; the children have to be taught to see what they are looking at, to hear what goes on around them, to know what they are touching. These children do not naturally *notice* things as a normal child does. They are taught simple games and simple handwork to give them coördination and overcome some of their awkwardness. After this, they are usually taught simple household tasks, by which they do what they can to support themselves in the institution. Some of them go through the first grade or two in school; some of the morons go as high as the fifth grade. But most of the later training is devoted to learning housework, weaving, embroidery, sewing, cooking, ironing, cobbling, gardening, or other like work.

The difficulties in teaching these people even such easy tasks are enormous. For instance, in teaching a boy to pull weeds, one must (1) teach him the difference between the weed and the plant and have him make this discrimination *several* times, (2) show him how to pull the weed without uprooting the plant and watch him do it until he has perfected the operation (he is sure to ruin at least a dozen plants first!), (3) see that he does not sit on the plants while he pulls the weeds, and (4) supervise him almost constantly to see that he keeps working. It takes a great deal of training to make such children able to do any work satisfactorily; but, with time and patience, they do learn. Practically all the labor of running a big institution is performed by the inmates, except, of course, the supervision.

If a feeble-minded person must be kept in the environment, it is necessary to find for him some analogous kind of work, of a very simple and routine nature, and then supervise him by seeing him frequently, having him report, explaining his condition to his immediate overseer, often handling his money for him, and so on. Such methods are not wholly satisfactory, but are clearly necessary in view of the great number of high-

grade defectives. The topic is dealt with more fully in the chapter on "Mental Hygiene." [1]

The following illustrative cases should make clearer the concept of feeble-mindedness.

Case No. 34

Name: Andrew M. *Age*: 21. *Sex*: Male. Born in small New England city. Single. *Sources of information*: mother and father, local doctor, local social agency, institution records.

I. History of the Family.
   A. Medical—Mother is feeble-minded (in institution). One sister is decidedly subnormal.
   B. Social—Mother was a prostitute before marriage. Two-room home was very dirty and smelly.
   C. Educational—Almost no education; mother cannot read or write.
   D. Economic—Father a teamster.

[1] Finally a word with regard to the treatment of individuals showing that combination of intellectual superficiality with physical and emotional weakness which has been called "constitutional psychopathic inferiority." (The group has been referred to in a previous note.) Such cases are chronic social problems, in many instances. They are hardly institutional problems. As with the group of the emotionally unstable, such a case frequently finds his way into a school for the feeble-minded, however (there to cause trouble), or even into a hospital for the insane. Both these last two types are obviously social problems and yet impossible of institutional solution, for practical reasons if for no reason else. The necessity for extra-institutional treatment of the socially and economically incapable comes to a head in the consideration of these cases. As things are now, the first step in treatment of the constitutional inferior is to get him out of the complex environment where his constitutional weakness is clearly preventing him from making any headway. He is too puny and weak to compete with the average man in the economic world. Usually, the constitutional inferior is out of a job! He cannot do work which is difficult and he lacks the "nerve" requisite for a place in criminal circles. So he goes through life vacillating from this occupation to that, unable to keep his feet for long in the struggle for economic existence, always trying to find some one to shield him from the stress of life. The trouble is obviously one which involves the health, the intelligence, and the whole personality of the individual and is, thus, one that cannot easily be dealt with. Simple work in a rural community or equally routine work in a very minor civil service position—situations where there is a lack of competition—form the best sort of solution to the problem. Unless such an individual is shielded and guided in some way he is likely to be chronically in difficulties and to become, early, a burden upon the community.

II. History of the Individual.
   A. Medical—Did not learn to take the breast until three or four months old. Has been paralyzed on left arm from birth. Did not learn to walk until admitted to institution at the age of nine. Has never learned to talk, save for "yes," "no," and one or two other words. Was always dirty in personal habits.
   B. Social—Was always noisy and destructive. Has outbursts of temper and smashes everything within reach. Never learned to play.
   C. Educational—Absolutely no schooling possible.
   D. Economic—Has always been a complete burden.

III. History of the Present Crisis.
   A. Medical—Nothing.
   B. Social—Became such a care and was so filthy that he was sent to an institution. Was irritable and uncontrollable.
   C. Educational—Nothing.
   D. Economic—Nothing.

IV. Present Condition.
   A. Physical.
      General Health—Fairly well developed generally except for withering of the left arm.
      Special Defects—One side of face paralyzed; face asymmetrical. Ears outstanding and not the same shape. Constant athetoid movements with fingers of right hand and a general rocking and swaying of the body.
   B. Appearance and Behavior—Sits in a chair, rocking back and forth to a sort of droning chant without, of course, any words. Voice hoarse and loud. Wiggles fingers in front of face constantly. Is almost never still. Occasionally he screams and tears his clothing.
   C. Intellectual Condition.
      General Level—Has an intelligence of about 1½ years.
      Special Functional Disorders—Judgment—none. Attention—no voluntary attention whatever. Memory—none. Can't recognize attendants. Association—nothing to note. Intake—sense organs seem normal.
   D. Emotional Condition.
      General Emotional Tone—Overexcitable.
      Special Emotional Trend—None evident, save as he is occasionally dominated by anger.

V. Summary and Conclusion.
   A. Summary—Very bad heredity. Paralysis—late development. Inability to talk. Destructive and filthy. Less intelligent than a normal child of 2.
   B. Conclusion—Idiot. (Excitable type.)

grade defectives. The topic is dealt with more fully in the chapter on "Mental Hygiene." [1]

The following illustrative cases should make clearer the concept of feeble-mindedness.

Case No. 34

Name: Andrew M. *Age*: 21. *Sex*: Male. Born in small New England city. Single. *Sources of information*: mother and father, local doctor, local social agency, institution records.

I. History of the Family.
   A. Medical—Mother is feeble-minded (in institution). One sister is decidedly subnormal.
   B. Social—Mother was a prostitute before marriage. Two-room home was very dirty and smelly.
   C. Educational—Almost no education; mother cannot read or write.
   D. Economic—Father a teamster.

[1] Finally a word with regard to the treatment of individuals showing that combination of intellectual superficiality with physical and emotional weakness which has been called "constitutional psychopathic inferiority." (The group has been referred to in a previous note.) Such cases are chronic social problems, in many instances. They are hardly institutional problems. As with the group of the emotionally unstable, such a case frequently finds his way into a school for the feeble-minded, however (there to cause trouble), or even into a hospital for the insane. Both these last two types are obviously social problems and yet impossible of institutional solution, for practical reasons if for no reason else. The necessity for extra-institutional treatment of the socially and economically incapable comes to a head in the consideration of these cases. As things are now, the first step in treatment of the constitutional inferior is to get him out of the complex environment where his constitutional weakness is clearly preventing him from making any headway. He is too puny and weak to compete with the average man in the economic world. Usually, the constitutional inferior is out of a job! He cannot do work which is difficult and he lacks the "nerve" requisite for a place in criminal circles. So he goes through life vacillating from this occupation to that, unable to keep his feet for long in the struggle for economic existence, always trying to find some one to shield him from the stress of life. The trouble is obviously one which involves the health, the intelligence, and the whole personality of the individual and is, thus, one that cannot easily be dealt with. Simple work in a rural community or equally routine work in a very minor civil service position—situations where there is a lack of competition—form the best sort of solution to the problem. Unless such an individual is shielded and guided in some way he is likely to be chronically in difficulties and to become, early, a burden upon the community.

II. History of the Individual.
   A. Medical—Did not learn to take the breast until three or four months old. Has been paralyzed on left arm from birth. Did not learn to walk until admitted to institution at the age of nine. Has never learned to talk, save for "yes," "no," and one or two other words. Was always dirty in personal habits.
   B. Social—Was always noisy and destructive. Has outbursts of temper and smashes everything within reach. Never learned to play.
   C. Educational—Absolutely no schooling possible.
   D. Economic—Has always been a complete burden.

III. History of the Present Crisis.
   A. Medical—Nothing.
   B. Social—Became such a care and was so filthy that he was sent to an institution. Was irritable and uncontrollable.
   C. Educational—Nothing.
   D. Economic—Nothing.

IV. Present Condition.
   A. Physical.
      General Health—Fairly well developed generally except for withering of the left arm.
      Special Defects—One side of face paralyzed; face asymmetrical. Ears outstanding and not the same shape. Constant athetoid movements with fingers of right hand and a general rocking and swaying of the body.
   B. Appearance and Behavior—Sits in a chair, rocking back and forth to a sort of droning chant without, of course, any words. Voice hoarse and loud. Wiggles fingers in front of face constantly. Is almost never still. Occasionally he screams and tears his clothing.
   C. Intellectual Condition.
      General Level—Has an intelligence of about 1½ years.
      Special Functional Disorders—Judgment—none. Attention—no voluntary attention whatever. Memory—none. Can't recognize attendants. Association—nothing to note. Intake—sense organs seem normal.
   D. Emotional Condition.
      General Emotional Tone—Overexcitable.
      Special Emotional Trend—None evident, save as he is occasionally dominated by anger.

V. Summary and Conclusion.
   A. Summary—Very bad heredity. Paralysis—late development. Inability to talk. Destructive and filthy. Less intelligent than a normal child of 2.
   B. Conclusion—Idiot. (Excitable type.)

CASE No. 35

Name: Ellen F. *Age*: 13. *Sex*: Female. Single. *Sources of information*: mother, older sister, teacher, institution records.

I. History of the Family.
   A. Medical—Mother is syphilitic and probably feeble-minded. Siblings probably defective.
   B. Social—Father deserted mother. Both parents immoral. Generally degenerate family. Has a brother who is colored. Mother says she doesn't know who is the father of some of the children.
   C. Educational—Mother illiterate. Children almost never attend school.
   D. Economic—Mother is an exceedingly poor housekeeper. Home filthy.

II. History of the Individual.
   A. Medical—Walked at three years, and talked about four.
   B. Social—Is fairly docile most of the time. Makes friends fairly readily among younger children. Has masturbated since early childhood.
   C. Educational—Finished first grade at eleven years, but never learned to read. Was in school six years.
   D. Economic—Learned to do some *very* simple housework.

III. History of the Present Crisis.
   A. Medical—None.
   B. Social—Girl played truant constantly. Got into sex difficulties with boys. Was reported by policeman as being on the street at night. Was committed to institution by the court.
   C. Educational—Was doing extremely poor work in school. In second grade.
   D. Economic—Nothing.

IV. Present Condition.
   A. Physical.
      General Health—General condition good.
      Special Defects—Cross-eyed. Asymmetrical face.
   B. Appearance and Behavior—Appears dull and listless. Almost no expression. Moves slowly and very awkwardly with shambling, stiff gait. Uses her hands awkwardly. Never seems to engage in any activity of her own volition.
   C. Intellectual Condition.
      General Level—Has I.Q. of 50, M.A. 6-4.
      Special Functional Disorders—Judgment—about what one would expect of a child of 6. Attention—very poor. Memory—very poor. Can't learn anything in school above

second grade. Association—exceedingly slow. Intake—apparently generally blurred (would run into things; could not turn definitely in the direction of a sound).

D. Emotional Condition.
General Emotional Tone—Apathetic. Is usually good-natured, but very stolid.
Special Emotional Trends—None evident.
Emotional Conflicts—None evident, seems perfectly happy in the institution.

V. Summary and Conclusion.
A. Summary—Some stigmata of degeneracy. Bad heredity, miserable home conditions—immorality and inability to learn in school. Very low intelligence, about equal to a six-year-old child.
B. Conclusion—Imbecile.

CASE No. 36

Name: George B. *Age*: 18. *Sex*: Male. *Birthplace*: Ohio. Single. *Sources of information*: institution records and officials.

I. History of the Family.
A. Medical—Mother and father both feeble-minded. Mother and three sisters are all in institutions; one sister is an idiot and the others are low-grade imbeciles.
B. Social—Mother was a prostitute. Never kept home clean. Gave children no care.
C. Educational—Neither father nor mother finished grammar school.
D. Economic—Father was day laborer.

II. History of the Individual.
A. Medical—Walked and talked rather late. Has always been slow-motioned, but is perfectly robust.
B. Social—Has lived in institution since he was a year old. Has always been obedient and coöperative. For the last five or six years has been the most trustworthy boy in the institution. Is gentle, lovable, patient and without any disagreeable characteristics.
C. Educational—Finished the fifth grade at sixteen years by means of persistent, patient work.
D. Economic—Was taught to care for the institution machines, trucks, etc. Is now working during the day in a near-by garage—about a block away from the institution. He knows how to take down or set up a Ford motor, but cannot learn to work with any other kind! Can repair a machine after he is shown what is the matter and is told what to do; can neither diagnose the trouble nor suggest the appropriate

treatment. Has no notion of the general principles in the construction of motors. Cannot apply what he knows about a Ford machine to any other type, even though the resemblances may be many. Can assemble a motor correctly and fairly quickly, but cannot explain *why* he does anything. Has simply learned what he knows by rote and hasn't any real comprehension of it. Is very useful in doing routine work of cleaning, etc., but needs constant supervision—not to make him work, but to keep him from making mistakes. Is an excellent example of a moron who is willing to work at the top of his ability, but who shows the limitations of that ability.

III. History of the Present Crisis—None.

IV. Present Condition.
- A. Physical.
  General Health—Excellent health.
  Special Defects—Slightly asymmetrical face and slightly awkward gait.
- B. Appearance and Behavior—Quiet and well-behaved. A little slow and awkward. Rather earnest manner. Is clean and neat in dress.
- C. Intellectual Condition.
  General Level—Has an I.Q. of 65.
  Special Functional Disorders—Judgment—fairly normal within limits of his information. Attention—about normal. Memory—rather poor. Has forgotten a large proportion of his school work. Association—slow.
- D. Emotional Condition—Perfectly normal.

V. Summary and Conclusion.
- A. Summary—Slow development. Awkwardness; facial asymmetry. Inability to do school work. Economic inefficiency. Mental age of ten.
- B. Conclusion—Feeble-minded—Moron.

Case No. 37

Name: Boise L. *Age*: 27. *Sex*: Male. Single. *Sources of information*: patient, older brother, eighth-grade teacher, hospital record, social agency which has been trying to help him.

I. History of the Family.
- A. Medical—Parents were alcoholic.
- B. Social—Father had a court record for petty thefts.
- C. Educational—Grade school education.
- D. Economic—Father was a ne'er-do-well. No settled occupation.

II. History of the Individual.
A. Medical—Has always been sickly. Was thought to be tubercular in childhood. Never has had much energy.
B. Social—Never played much with other children; seemed to be interested, but didn't have the energy. Was never noisy or rough like most boys. Was terribly afraid of being "hurt," so he wouldn't join in any games. No spontaneity. Was (according to teacher) "mean" and "small" and "very selfish."
C. Educational—Finished ninth grade; work was fair, but he was always uninteresting and lacking in any originality. Was always very childish in his work; always seemed to grasp things in the most limited way.
D. Economic—Since leaving school has tried many jobs but never could keep one more than a month. Refused to attempt any kind of manual work; was always looking for a soft job.

III. History of the Present Crisis.
A. Medical—Has been sick for a week or two—nothing but a cold, but he seems to have lost what little energy he ever had.
B. Social—Has been dependent upon charity during sickness. Has complained because the provisions sent him were not of the choicest.
C. Educational—Nothing.
D. Economic—Lost his last job—running an elevator—over a month ago, after staying with it a day. Since then has been waiting for something to "turn up."

IV. Present Condition.
A. Physical.
General Health—Small build. Childish contours. Undernourished. Very white skin. No stamina. Little facial or pubic hair.
Special Defects—No special defects.
B. Appearance and Behavior—Fastidiously dressed. Hands cared for immaculately. Calls attention to fact that his tie and socks just match his eyes! Is listless and lazy. Takes only a polite interest in those about him. Seems fairly well informed, but has the narrowest possible outlook on everything. Speaks with a childish lisp.
C. Intellectual Make-up.
General Level—Has an I.Q. of 78.
Special Functional Disorders—Judgment—has some vague ideas that other people are more lucky than he, that he has never had any fair chance, that all the good jobs are already taken, that you can't get along unless you start with money, etc. Is extremely self-centered and selfish. Attention—

wandering; he can seldom tell a story without diversions. Memory—normal. Association—normal. Intake—normal.

D. Emotional Condition.
General Emotional Tone—Apathy, indifference, boredom. Special Emotional Trends—None. Complains of things in a weak, petulant way, but no strong feeling.
Emotional Conflicts—No evidence of conflicts. Would willingly stay in hospital indefinitely if he was assured of heat, clothing, and food.

V. Summary and Conclusion.
A. Summary—Underdevelopment, childish build and characteristics. Poor health. Lack of energy. Content to live on charity or any one else who will support him. Inefficiency for any kind of work. Apathy. Laziness, vanity, and selfishness. Weak, flabby, "grouch" against society. No spontaneity. Narrow understanding.
B. Conclusion—Constitutional Inferior.

The chapter may be briefly summarized. (1) Feeble-mindedness is to be understood as a condition of general mental inadequacy due to incomplete mental development, not to progressive mental disease; the condition is thus logically distinguished from dementia. (2) The feeble-minded are classified according to the degree of their defect as (a) idiots, (b) imbeciles, and (c) morons. A borderland group of (d) the constitutionally psychopathic inferior may also be distinguished. (3) Since the feeble-minded are individuals of incomplete development the history is evidently of great importance, and shows inadequacy usually practically from birth. (4) The diagnosis may evidently often be difficult since the differentiation is a matter of *degree* of inadequacy; active symptoms of a disease process are not ordinarily to be expected. It is suggested that for a diagnosis of feeble-mindedness there should be marked evidence of (a) educational inadequacy, (b) economic inefficiency, (c) social inadequacy, and (d) intellectual inferiority as shown by tests of intelligence. (5) Finally something is said regarding treatment and care of the feeble-minded—a topic which will be touched upon again in Part III.

References—Part II

The references below are suggestive of the various lines of work being done in the fields indicated—where no specific chapters are mentioned the reader is advised to glance through the entire book.

1. On the Normal Individual.

Healy, W., *Mental Conflict and Misconduct* (Case-Studies).
——— *Pathological Lying, Accusation and Swindling* (Case-Studies).
White, W., *Mechanisms of Character Formation,* Chaps. 4, 5, 6, 7, 10, 11, 12.
Devine, E. T., *The Normal Life.*
Wells, F. L., *Mental Adjustments.*
Groves, E. R., *Personality and Social Adjustment.*
Groszman, M. P., *The Exceptional Child,* Part I, Chaps. 5-6.
Morgan, J. J. B., *The Psychology of the Unadjusted School Child.*
Malchow, C. W., *The Sexual Life.*
Robie, W. F., *Rational Sex Ethics.*
Freud, S., *Three Contributions to the Theory of Sex.*
Burnham, W. H., *The Normal Mind.*

2. On the Borderland Conditions.

Diefendorff, A. R., *Clinical Psychiatry,* pp. 457-535.
White, W. A., *Outlines of Psychiatry,* Chap. 16.
Myerson, A., *The Nervous Housewife.*
Rosanoff, A. J., *Manual of Psychiatry,* Chaps. 3, 8 (Part II).
Kraepelin, E., *Lectures on Clinical Psychiatry,* Chaps. 25, 27-30.
Dejerine, J. J., *The Psychoneuroses and Their Treatment.*
Frink, H. W., *Morbid Fears and Compulsions,* Chap. 9 (Case-Studies).
Mateer, F., *The Unstable Child.*
Freud, S., *Selected Papers on Hysteria and Other Psychoneuroses.*
Dubois, P., *The Psychic Treatment of Nervous Disorders,* Chaps. 9, 10, 13, 14, 15, 20, 22-29.
Albutt, C. A., *War Neuroses.*
Yealland, L. R., *Hysterical Disorders of Warfare.*
May, J. V., *Mental Disease,* Chaps. 11, 16, 17, Part II.
Kempf, E. J., *Psychopathology,* Chaps. 5, 6, 7.
Anderson, V., *The Hobo,* Chaps. 1, 2, 5, 6, 7, 12, 13.
Southard, E. E., and Jarrett, M. C., *The Kingdom of Evils,* III, Chaps. 10, 11.

3. On Functional Psychoses.

Diefendorff, A. R., *Clinical Psychiatry,* pp. 219-276, 348-433.
White, W. A., *Outlines of Psychiatry,* Chaps. 7, 8, 10.
Rosanoff, A. J., *Manual of Psychiatry,* Part II, Chaps. 4-7.
Kraepelin, E., *Lectures on Clinical Psychiatry.* Chaps. 1-4, 7-9, 15.
Kempf, E. J., *Psychopathology,* Chaps. 8-13.
Varendonck, J., *The Psychology of Day Dreams.*
May, J. V., *Mental Disease,* II, Chaps. 11-14.
Southard, E. E., and Jarrett, M. C., *The Kingdom of Evils,* III, Chaps. 8, 9.

4. On the Organic Psychoses.

Diefendorff, A. R., *Clinical Psychiatry,* pp. 115-218, 276-322, 323-348, 434-456.
White, W. A., *Outlines of Psychiatry,* Chaps. 9, 11-14.
Kraepelin, E., *Lectures on Clinical Psychiatry,* Chaps. 5, 6, 10-12, 14, 18-20, 22, 23, 26.
Crothers, T. D., *Inebriety.*
May, J. V., *Mental Disease,* II, Chaps. 1-10.
Southard, E. E., and Jarrett, M. C., *The Kingdom of Evils,* III, Chaps. 1, 3-6.
Rosanoff, A. J., *Manual of Psychiatry,* Part II, Chaps. 2, 9-22.
Solomon, H. C., and M. H., *Syphilis of the Innocent.*

5. On the Feeble-minded.

Barr, M. W., and Maloney, E. F., *Types of Mental Defectives.*
Diefendorff, A. R., *Clinical Psychiatry,* pp. 536-548.
Tredgold, A. F., *Mental Deficiency,* Chaps. 5-16.
White, W. A., *Outlines of Psychiatry,* Chap. 17.
Rosanoff, A. J., *Manual of Psychiatry,* Part II, Chap. 1.
Goddard, H. H., *Feeble-mindedness: Its Causes and Consequences,* pp. 47-434 (Case-Studies).
Kraepelin, E., *Lectures on Clinical Psychiatry,* Chaps. 24, 31-32.
Doll, E. A., *Clinical Studies in Feeble-mindedness* (Case-Studies).
Huey, E. B., *Backward and Feeble-minded Children.*
Southard, E. E., and Jarrett, M. C., *The Kingdom of Evils,* III, Chap. 2.

Exercises in Application

1. Write a complete case study of some individual you know who in your estimation is normal, but who might be considered

abnormal if he were investigated after being arrested on some incidental charge. Point out especially the unusual characteristics and show what adaptation the individual has made so that he is an acceptable member of society.

2. Make a list of actual experiences from your own childhood and that of your friends, of the following types of misbehavior: (1) childhood stealing, (2) childhood sex experiences, (3) childhood lying, (4) childhood truancy, and running away from home, (5) childhood destruction of property—setting fires, etc. The instances should be actual experiences, but need not be your own. How much "delinquency" seems to be "normal" among children?
3. Make a list of the "mental mechanisms" that you have read of that may be used in meeting conflicts—such things as rationalization, "sour grapes," etc. Give an example from your own experience of each of these mechanisms, showing the nature of the conflict and how it was met.
4. Write case studies of any individuals you have known who would merit any one of the following diagnoses: neurasthenia, hysteria, psychasthenia, dementia præcox, manic-depressive insanity, paranoia.
5. Describe any old person you have known who lived into "second childhood" or showed any mental peculiarities. What is your diagnosis?
6. If you have known any case which you think suffered from general paresis, give a full description. What were the consequences for the man's family? What happened to his business?
7. Describe in detail some fit or convulsion that you have witnessed. Include also in your report the age of the individual, his disposition, the frequency of attacks, and anything else that might be of interest. What is your diagnosis?
8. Make out case studies of any feeble-minded children or adults you have known. From your own studies and from examination of similar cases in the readings make a list of the outstanding characteristics of feeble-mindedness, classifying these characteristics under the headings of the case-study outline, and noting the per cent of the cases having each one of these characteristics. Do these results indicate that delinquency is universal among the feeble-minded? Poor work in school? Inability to earn a living?

PART THREE

MAJOR PROBLEMS AND METHODS OF DEALING WITH THEM

CHAPTER XI

SOME PROBLEMS OF DIFFERENTIAL DIAGNOSIS

In the previous four chapters various abnormal mental types and pathological conditions have been taken up and the most distinctive and characteristic features of each condition or type pointed out. The reader may have noticed, however, that a number of different kinds of mental difficulty seem to have the same "distinctive" symptoms. An attempt to "diagnose" two or three of his most peculiar acquaintances will also bring home to the reader the appreciation that it is much easier to proceed from diagnosis to symptoms (as in the cases of a textbook) than it is, from a multiplicity of symptoms, to decide upon a diagnosis. The present chapter will discuss certain problems of differential diagnosis which are particularly difficult—and also frequently met with. An effort will be made to elucidate these problems so far as possible, and also to make clearer methods of differential diagnosis.

Delinquency and Psychopathy

A new era dawned in the study of criminalistics when it came to be realized that asocial conduct might be explained medically. Then, of course, there was a tendency to consider all offenders against the law psychiatric problems. It is now quite generally appreciated that the situation is by no means so simple. The majority of the cases before a court are cases for the law, alone, to deal with, and not the clinician.[1]

[1] It seems not always to be understood that the cases dealt with by a court psychiatrist or psychologist are not *all* cases passing through that court, but only certain of the cases which the court believes need such examination—because of peculiar behavior, repeated delinquency, or

However, the chronic police problems are very likely to be well-marked mental types; so it is always well to study such cases carefully for evidences of mental pathology. Study of court cases from this point of view, however, is a matter involving considerable responsibility. Further, the situation is often such that simulation of a pathological mental condition may be suspected. So a very thorough, systematic procedure is desirable. In studying criminals it is well to eliminate possibilities somewhat as follows:

In the first place, (1) is the case psychotic?[1] If he is, the matter is settled then and there, and (the most important matter from the practical point of view) the disposition of the case is settled; he should go to a hospital for the insane. If the case *is* psychotic, there should be frank symptoms. There should be evidences of delusion—very possibly the delusion may have been involved in the criminal act. There may be evidences of a distinct maniacal condition; again the criminal act is very likely accounted for by the mental state. Unmistakable hallucinations may possibly be related to the patient's conflict with the police; anyhow, there is so much excellent evidence for psychosis. A confused, dazed condition with occasional excitement, restlessness, and perhaps scars on the head, suggests epilepsy and makes imperative further inquiry along this line. Indications of excessive alcoholism have an obvious significance. Evidences of psychosis are, then, first to be looked for since they are usually the most readily obtained, and since such a diagnosis has the right of way, in determining the disposition of the case, over any other classification which might be made.

The mental examination must, of course, be accompanied

other suggestive features. The per cents reported by the court physician may be per cents *of cases so referred*, not of the total number of cases actually dealt with by the court.

[1] The very first question, of course, in dealing with the various diagnostic problems mentioned in this chapter, should be, Does the case have any physical disease? The assumption is here that this question has been considered, and no important physical disease or disability found dominating the situation.

by a physical examination, which may be expected to yield much confirmatory evidence if mental disease appears to be present. A Wassermann should always be taken. The physical examination will also reveal evidences of the syringe if the case is a drug addict.

Simulation is relatively unlikely. Insanity is hard to imitate. The excitement of mania no normal person can maintain; the strain is too much. Most people know too little about the nature of either hallucinations or delusions to give a type picture which fits any of the recognized disease entities. The oddities of dementia præcox are altogether inimitable. A simulator may, however, give a picture of a mixed condition which is not unmistakably false. Usually he overplays the part. But sometimes minor tricks must be resorted to, for the clearer elucidation of the situation. The truly insane case is likely to be more peculiar when he thinks he is alone and unobserved than when with other people; when other people are watching he tries to pull himself together. The simulator does just the opposite and calms down to rationality when he thinks no one is about. The simulator may also be occasionally frightened by commonplace remarks with regard to an insane hospital for life, etc. . . . Where deception appears likely, ways of checking up on the situation will naturally be suggested and worked out according to circumstances.

If the case is not psychotic the investigator probably hopes that (2) the delinquent is feeble-minded. Here, particularly, the hope of thus easily disposing of the situation may illicitly influence the conclusions. It must be understood emphatically that delinquency is not evidence in itself of mental defect. In order to diagnosis the case as feeble-minded, four bits of data are (as has been said before) of prime importance. There should be evidence that the case (a) was strikingly incapable in school, (b) is capable of doing only the simplest kinds of work, (c) is clearly inadequate in his various social relations, and (d) makes a showing on a *satisfactory* psychological

examination indicative of a mental age of ten or below.[1] Evidences of poor heredity and chronic delinquency may give confirmation to the conclusion but are not essential. If the case is clearly feeble-minded that usually largely explains the criminal career; the criminality is evidence of either poor inhibitions or economic inadequacy with recourse to criminal methods. The disposition will be also settled by the diagnosis if, in the particular state in which the examiner is working, provision is made for the adult feeble-minded, and if the state institutions are not so extremely crowded that early commitment is out of the question.

It has been insisted that "social feeble-mindedness" as shown in delinquency or irresponsibility is not in itself a basis for diagnosis of "f. m." If the term feeble-minded is to have the definite practical connotation it should have, it should be applied only to those who show a marked incapacity for the acquirement of new ideas, or learning, and for even mildly complicated processes of thought—and who have shown this incapacity since an early age. The individual must be economically and educationally *impossible.* For such cases institutional life, with simple work under supervision, is the desideratum. The cases who can work but will not, and are delinquent from mere lack of emotional control, do not present the same problem as the feeble-minded, usually make trouble when put with the feeble-minded in institutions, require a different kind of supervision, a different kind of training, and have a very different prognosis. Since the unstable psychopaths are in most states not definitely recognized by the law, and not provided for either institutionally or otherwise, it may occasionally be advisable to classify such a case as feeble-minded for purposes of disposition. But the clinical psychologist and psychiatrist should keep their own thinking free from any such confusion.

Simulation of feeble-mindedness is by no means as common as simulation of insanity. There is lacking the dramatic element, perhaps—and then it must hurt any one's self-respect to appear any duller than he is. But some cases balk or "grouch," so that it is hard to size up their intelligence; others

[1] If the case is a child, an I.Q. definitely below 70 (ordinarily not above 65) should be required.

have sometimes been told to answer no questions, and so are noncommittal on the tests. Here observation of the individual's general alertness and inconsistent successful reaction to hard tests will usually give clews to the situation—a situation which will be opened up by sympathetic questioning.

If the case is neither psychotic nor feeble-minded, he has not that definite status before the law which will make a disposition, on the basis of mental condition, readily obtainable. Only if the case is psychotic or feeble-minded can he be considered, unmistakably, not a legal problem at all but a medical problem. There are other diagnoses, however, which may illuminate the situation, though they may not be recognized by the court. The case may be, in the third place, (3) a psychopathic personality. As was pointed out in the discussion of the emotionally unstable, the symptomatology of that condition is, in many cases, little more than repeated and inveterate delinquency. There are also (4) cases which appear to compensate for an emotional conflict by delinquent acts. Kleptomaniacs are probably examples of this. In fact, any one of the borderland conditions may involve an individual in delinquency. The condition can hardly be thought of as making the individual irresponsible. But a diagnosis of hysteria tells much about a delinquent girl, or, perhaps, an overemotional and alcoholic swindler.

If the case cannot be properly classified in any one of the groups above referred to,[1] the worker should show his courage by refusing to make a diagnosis and by manfully asserting that the case is not pathological.[2] He may even conclude that the case is a case primarily of professional criminalism. There

[1] To which should be added the group referred to in Chapter VII as the mentally peculiar. Since most borderland cases seen in court appear to be of the first two types, only these two have been mentioned in the text, however.

[2] The case may, of course, be not pathological but the victim of circumstances. Then in particular intensive study is worth while, and warrant given for every possible effort at reconstruction. It is such cases in particular that the investigator should hope to find. . . . And of course for all the borderland cases much can usually be done.

are such individuals. They are more likely to deceive and play upon the sympathies of the court than any other type. And if the clinician attached to the court can make it his business to study such gentlemen, it may turn out to be well worth while.

Economic Incompetency and Psychopathy

Much the same possibilities hold for those individuals coming to a social agency, chronically, as needing help. The case may be psychotic. The case and the family may be feeble-minded; but the worker must not use this classification as a waste-basket classification, where all the otherwise unclassifiable go. Economic incapacity may be due simply to a long-established antipathy to work; it may be due to a long-established antipathy to bosses, which brings early discord and discharge in any commercial establishment. There may be a real emotional difficulty which cuts down the individual's efficiency to the point where he is no longer employable. In fact, many social cases have such elements, hidden way down deep, and unsuspected at first. Then something of an emotional reëducation is necessary, and there is a situation which is most likely to reward the patient social worker. But it must be remembered that mental pathology may be related to economic incapacity in a great variety of ways, and that the economically incapable may perfectly well actually be the victims of economic depression, economic oppression, or other circumstances which might bring about a neurotic condition but which are to be looked back to for an understanding of the entire drift of affairs.

Social work, of course, usually involves the family rather than the individual. Perhaps the most important thing to remember under these circumstances is that the social heredity of the family (by which the writers mean the total set of attitudes, the emotional tone, and habit of mind which the patient finds at home and which has surrounded him from the very earliest age) is probably tremendously important.

Psychiatric research has emphasized the importance of early childhood sex experiences. It is surely quite possible that other experiences have their lasting influences, and that a family which is rough and brutal, or shiftless and irresponsible, or discouraged and disheartened by poverty or illness, may have a tremendous influence over the children who grow up in that family. Not merely the individual but usually also his family must be studied—and treated.

Non-educability and Psychopathy

The school psychologist has to deal with problems distinct, for the most part, from the problems mentioned in the preceding section. Particularly is the concept of feeble-mindedness in certain respects different, as is the eliminating procedure in the diagnosis of the case. In dealing with "a problem child" the major possible causes to eliminate first, in accounting for the educational problem, are physical.[1] In the first place, has the patient any physical disease such as tuberculosis, which is chronically impairing health? Or, has there been a debilitating disease such as pneumonia? Such possibilities are usually easily covered. The possibility of sensory defect is also readily eliminated in most instances. Marked near-sightedness can readily be detected, and also deafness of an appreciable degree. Other defects of vision, such as far-sightedness, should be investigated by an oculist.[2] Such a nervous disease as chorea should always be inquired after, where there is any possibility that it is latent. Information with regard to the

[1] As has already been said, in dealing with *any* case the possibility of physical disease is always to be considered. In dealing with school children this is especially important because such physical handicaps are common, often overlooked by the school authorities, usually easily dealt with, but cumulative in their effects if neglected. Sometimes wonders can be done for a child by an adequate physical overhauling.

[2] Far-sightedness is common in school children, is not to be detected by the usual test charts for determining visual acuity, and is most harmful to the child since use of far-sighted eyes in the school work results in headaches and a variety of other symptoms. When a child has persistent headaches, appears to experience discomfort in the use of the eyes and is irritable following such work, he should be sent to an oculist at once. Neglect is very serious.

environmental situation at home is very important; very frequently unusual home circumstances will account for a great deal. Especially may an unfortunate emotional life, going back (often in obscure ways) to such circumstances, be at the center of difficulties.

If these preliminary inquiries do not give the cause of the trouble and there is a suggestion of feeble-mindedness, a careful use of tests with shrewd observation of the child, together with careful study of school record to date, should settle the matter—study of play habits and relations to other children having a part in the diagnosis. It should be noticed that feeble-mindedness of necessity does not mean quite the same thing in school as in court; inevitably the nature of the problem and the possibilities in the way of disposition have their influence upon the significance of the diagnosis. In school, the major problem is the inability to learn. And the most natural disposition is the special class.

If the case is not feeble-minded, he may still be duller than average. Special help from the teacher, perhaps in an ungraded class, will help. There is the possibility, of course, that the case may be epileptic. The problem is then primarily medical. The case may be markedly unstable; and there is a temperamental problem often very complex and baffling but sometimes largely solved by developing opportunity for vigorous physical interests. The neurasthenic child is not uncommon. Such cases are probably to be understood as a combination of lack of physical vigor plus an emotional difficulty, and are to be handled with both of these points in mind.

If none of these various groups seem to fit the child in question, it might as well be admitted that there is a possibility that the school is at fault! Perhaps some of the most striking cases of educational difficulty are the very bright children one finds occasionally, who fail to get along well in school because the school fails to interest and stimulate them. The writers have recently learned of a case of confirmed truancy completely cured by double-promotion.

Differentiation of Adolescent Pathological Mental Conditions

Frank mental disease is a rare thing in childhood.[1] With the stress of adolescence, however, a variety of emotional and mental conditions may appear, a majority transitory, but some most grave. Some of the most persistently troublesome problems in psychiatry are involved in differentiation of these cases. Temporary neurotic states in adolescence are probably extremely common (a fact which should bring some relief to both adolescents and their parents, since both parents and adolescent usually aggravate such conditions by regarding them as very strange and unusual). The big difficulty in diagnosis is that the grave psychoses are very likely to begin with a neurotic—particularly a neurasthenic—condition. Whether there is a genetic relationship or not, the similarity between these various conditions is so great that much confusion is possible, in fact, inevitable. The neurotic conditions which are transitory are perhaps to be distinguished from those which usher in a psychosis by the more superficial nature of the condition, and by a study of the earlier personal history. The individual merely neurasthenic is more responsive to his environment, forgets his troubles more easily when he is interested; there is a general impression of a less deep-rooted condition. The emotional difficulty which is back of the condition is likely to be more explicit, more recent, and more readily get-at-able.

This takes one back, of course, to the previous life of the individual, and one may dread dementia præcox in proportion as the previous condition shows a pre-dementia præcox seclusiveness and a delayed development suggestive of inadequate vitality; or a depressed episode may be looked for if the in-

[1] There may, of course, be epileptic manifestations, hysteria, neurasthenic conditions. There are also various somewhat obscure temporary conditions of depression and mental perturbation just before adolescence which are rather common. Very rarely, indeed, manic-depressive insanity appears in childhood, or dementia simplex seems to have its beginning thus early.

dividual is of a "cyclothymic constitution"—that is, markedly emotional with periods vaguely suggestive of mania or depression.

If the psychosis is once under way, the differentiation may be, in some cases, easy. Catatonic stupor is usually unmistakable. So is hypomania, usually. But catatonic excitement and manic conditions may be practically indistinguishable at first. In dementia præcox, however, there is less distractability by external circumstances. The activity is more from within and it is more stereotyped and more meaningless. Depressed conditions may appear either in dementia præcox or in manic-depressive insanity. But the relative indifference and apathy of dementia præcox may be a means of distinguishing a case which is a true dement; a stiffness and awkwardness in movement and in thought also suggest præcox, as do hallucinations.

It should be admitted, however, that it is sometimes simply impossible, early in the diseased condition, to tell whether the case is manic-depressive or dementia præcox. One can only wait and see whether the case dements or not. Under such circumstances the differentiation, which is primarily a differentiation between a dementing and a non-dementing psychosis, becomes something of a tautology. . . . The affair may turn out, after all, to be no more than an unusually severe neurotic episode. The amount of the matter is that only the merest glimpses have, as yet, been obtained regarding the nature of adolescent mental difficulties.

It should be realized, in dealing with an early neurotic condition, that something needs to be done, and done at once. The situation is usually not so much medical as emotional. Very often the family physician does more harm than good by prescribing a tonic and rest, thus developing hypochondria and giving special opportunities for the morbid broodings to develop. This question of treatment will be returned to in a later chapter. Here it is necessary only to emphasize the importance of early study of the case, with due consideration

of psychogenetic factors and intimate problems of social adjustment and emotional development as possible causes. There may then be not merely classification of the condition, but a real understanding of it—and so the possibility of constructive treatment.

Mental Difficulties of Middle Age

A word remains to be said with regard to the understanding of mental difficulties appearing in the prime of life. Dementia præcox may appear late; but usually it may be assumed that the difficulties of adolescence have been weathered safely and with no important residue of emotional deformity. The physical examination should be given very careful consideration. If there are no evidences of physical disease, such as diabetes, and no evidence of alcohol or drug addiction, such a situation can be rapidly simplified. The possibility of manic-depressive psychosis appearing for the first time in a person of middle age is relatively slight. The one thing to be thought of, in a progressive, somewhat indeterminate mental condition, is general paresis. Here the laboratory findings will be the most important evidence.

Classification and Individualization in Diagnosis

So much, then, with regard to these problems of diagnosis. The differentiations may seem easy. However, if the reader will (as was suggested in the first paragraph of this chapter) attempt diagnosis of two or three cases he knows, he will realize something of the complexity of this subject, and the difficulties involved in such judgments.

A word remains to be said regarding the fact that, from certain very important points of view, any diagnosis at all is unfortunate! A few lines back it was remarked, in discussing problems of adolescence, that adequate study should result "not merely in classification of the condition, but in a real understanding of it." In the first chapter it was emphasized that problems of mental health and disease are highly indi-

vidual; in certain very important ways no case is like any other. An investigator should never feel satisfied once he gets a case pigeonholed under a a descriptive diagnosis. Such classification is of course an important step. But if there is to be any attempt at constructive dealing with the case, there must be a much more particular and intimate understanding.[1] So this chapter on diagnosis ends with a warning of the inadequacy of the usual procedure. All too often study of a case ends with its reference to one of the disease groups mentioned in Part II. Some workers seem to feel that there is some peculiar virtue in a diagnosis—that somehow the diagnosis did the patient some good. As a matter of fact, a diagnosis should be simply a first generalization in study of the case. Very often the study must, because of limitations of time and energy, stop with such a classification. But it should always be a matter of regret with the investigator; the effort should be for an intimate personal understanding of the individual.

To summarize: the most troublesome diagnostic problems which the school official, social worker, personnel manager meet have to do with (1) delinquency and psychopathy, (2) economic incompetency and psychopathy, (3) non-educability and psychopathy, (4) the differentiation of adolescent pathological mental conditions, and (5) mental difficulties of middle age. It is believed that the present chapter—in supplementation to what has been said in Part II—will give some orientation in dealing with these difficult topics. It is finally to be emphasized, however, that really adequate investigation of a case involves not merely classification of a case under a certain diagnosis, but also close study of the case as an individual problem.

[1] The writers are, of course, thinking primarily of the various functional conditions. A general paretic hardly warrants such study. In dealing with a psychoneurotic it is vital.

CHAPTER XII

EXTENT OF MENTAL DISEASE AND DISABILITY

A word should now be said with regard to the prevalence of the various types of mental difficulty described in Part II, the expense of treatment and loss (direct and indirect) due to mental disease and disability, and the relation of mental disease and deficiency to educational, social and economic problems.

The Number of Individuals in Institutions

The natural first question is as to the number of individuals so abnormal as to be placed in institutions. A census recently taken by the National Committee for Mental Hygiene showed a total of 290,107 individuals in institutions for the mentally diseased, the epileptic, and the feeble-minded in the United States on January 1, 1920.[1] Of these, 232,680 were patients in hospitals for the mentally diseased, 14,937 were in institutions for the epileptic, and 40,519 were in institutions for the feeble-minded. There were also 1,163 alcoholics and 808 drug addicts in separate institutions for such cases. These individuals all were actually in institutions at the date of the census. In addition, there were 18,268 cases reported by the hospitals for the mentally diseased as on parole, escaped, or otherwise on the books but not then in an institution.

The vast majority of these cases are cared for in public institutions; mental disease, unlike physical disease, does not

[1] Pollock, H. M., and Furbush, E. M., "Patients with Mental Disease, Mental Defect, Epilepsy, Alcoholism, and Drug Addiction in the United States, January 1, 1920," *Mental Hygiene*, Vol. 5, pp. 139-69, 1921. For later data appearing since this chapter was written see same journal, Nov., 1925.

seem to appeal to philanthropic individuals in such a way as to lead to the founding of private hospitals or other endowed institutions. Instead, private sanitariums are much more likely to be money-making concerns. As a matter of fact, the census showed only 13,705 of the cases to be in private institutions, or less than five per cent. The burden is then borne in large part directly by the public.

A somewhat different light on the situation is obtained if these figures are construed so as to show the proportion of institutional cases to the general population. There are approximately 274 individuals in institutions for mental trouble of one sort or another (in hospitals for mental disease, colonies for the epileptic, or "schools" for the feeble-minded) out of every 100,000 of the total population of the country. There are 220 individuals out of every 100,000 in hospitals for the mentally diseased. In every 100,000 there are 38 cases in institutions for the feeble-minded. And there are 15 cases in institutions for the epileptic. Such numbers surely suggest that the problems of mental disease and disability are by no means negligible.

Analysis of the cases, in the hospitals for the insane, with regard to type of mental disease throws further light on the situation.[1] Roughly about a quarter of patients admitted to hospitals for the insane are classified as some form of dementia præcox (28% in the twelve states studied by the National Committee for Mental Hygiene). Dementia præcox thus appears of importance because of the frequency of its occurrence. It is also important economically and socially because it disables the individual early in life and because (since the condition is not fatal) such cases may live to a good old age, a continued burden on society. So, while dementia præcox cases make up a good quarter of the admissions to state hospitals, they constitute about half of the institution populations, because of this longevity and the usually irrecoverable nature

[1] Pollock, H. M., and Furbush, E. M., "Mental Diseases in Twelve States in 1919," *Mental Hygiene*, Vol. 5, pp. 353-89, 1921.

of the disease. In the discussion with regard to dementia præcox it was suggested that the condition might be largely psychogenetic, and that important developments in the understanding and treatment of the condition, and prevention, might be soon expected. It is evident from the above figures that any such advances would be very important, since they concern a disease so largely prevalent, and so much a burden.

About one-seventh (14.8% in the census above referred to) of the yearly admissions to hospitals for the mentally diseased are cases of manic-depressive psychosis. Add to this the dementia præcox group, and the comparatively few cases of paranoia (1.7%) not classified in with dementia præcox, and there is a total for the functional psychoses of around 45% of all admissions. Further—as has already been intimated—the proportion of these functional cases in institution populations is even greater.

About 17% of all admissions are due to some one of the various conditions appearing in old age, either senile or presenile conditions (11.4%) or arteriosclerosis (5.5%). Around 10% (9.9%) of admissions are general paresis. In the past around 20% have been toxic psychoses, due to alcohol or drugs. This percentage has markedly decreased, however, in the last two or three years and particularly since prohibition (about 5% in 1919). Use of both alcohol and drugs seems to be diminishing; elimination of alcohol is not bringing about the greater use of drugs which was predicted by some people.[1] Admissions to state hospitals for alcoholic conditions or drug addiction were about five times as numerous in 1917 or in 1910 as in 1920. The latest figures show a slight increase in numbers of such cases in 1922 over 1920, however.[2]

The remaining 15 or 20% of admissions are made up of various small groups of cases, such as epileptic insanity, extreme cases of psychopathic personality, psychoneuroses, and

[1] See Pollock, H. M., "Decline of Alcohol and Drugs as Causes of Mental Disease," *Mental Hygiene*, January, 1921, Vol. V, pp. 123-29.

[2] Pollock, H. M., and Forbush, E. M., "Prohibition and Alcoholic Mental Disease," *American Review*, Vol. 2, pp. 142-54, 1924.

so on. The important groups, in the hospitals for the mentally diseased, are dementia-præcox and manic-depressive insanity, the senile and presenile conditions, the toxic conditions, and general paresis.

The practical individual will at once inquire as to the cost of maintenance of this small army of individuals in the institutions. The latest satisfactory figures appear to be for 1918. Data for that year show the total cost of maintaining the patients in the state hospitals for the mentally diseased as $48,561,124.05. Then the average per capita cost was $244.21. One-sixth to one-third of every state's expenditures is for these institutions. The total property value of hospitals reporting in this investigation (most but not all of the state institutions reported) was placed at $197,261,782. New York State alone had over $40,000,000 invested in its institutions. And it should be pointed out that these figures are only for the state institutions for the mentally diseased; they do not cover either the private institutions or the state institutions for the feeble-minded, epileptic, or inebriate.

It should not be forgotten that the cost of institution care is not the only loss to society involved in these conditions. There is obviously the loss of whatever contribution to society these individuals might have made if they had been mentally well and strong; this loss is most obvious when (as is so often the case with general paresis) the mental condition leads to business mistakes, and a family is left in want. Loss from criminal or destructive acts prior to commitment is not negligible. And there is the further fact that many of these cases have propagated their kind and so continued all these burdens.

The Number of "Institutional" Cases not in Institutions

The number of cases in institutions is surely great enough. However, it has been emphasized repeatedly in the previous chapters that not all mental deviates are in institutions. It is, of course, no easy matter to estimate the number who are not thus definitely located geographically as certified mental

problems. Recent community studies have given some information which permits inferences in regard to this matter, however. Thus the Indiana Board of State Charities, working through a special committee appointed by the Governor, has considered the problem of the mentally diseased and defective as they appear in the community.[1] Field workers were sent out by this committee into eight counties, chosen as representative of various sections of the state. The workers went through these counties systematically, visiting the schools, obtaining confidential information from the local physicians, pastors, and others intimately in touch with the neighborhood, and visiting individuals suspected of mental defect wherever such a visit was possible.

On the basis of this study it was estimated that in Indiana there were a total of about three thousand cases who were insane, but were not in an institution or receiving any special care. Some of these cases needed institutional care and some did not; a conservative estimate placed the number needing such care at between fourteen and fifteen hundred. Indiana has five hospitals for the insane, caring for a total of between five and six thousand patients. It was estimated that about 20% of all insane cases in the state needing institutional care were not receiving such care.

The situation with regard to the epileptic was much more critical. Briefly, it was estimated that there were about thirteen hundred epileptics at large in the community, needing institutional care, and about twenty-five hundred more epileptics at large, but not needing institutional care at present. The total estimate of epileptics at large in the communities was thirty-eight hundred. The one state colony for epileptics admitted only men and was woefully inadequate. It was estimated that 80% of the epileptics in the state needing institutional care were not receiving such care—that only 20% of

[1] The investigation is summarized in the Second Report of the Indiana Committee on Mental Defectives, *Mental Defectives in Indiana*, Indianapolis, December 27, 1918.

the total number of epileptics were in the state institution for such cases.

Still more striking was the situation with regard to the feeble-minded. In the one state school for the feeble-minded there was a total of fourteen hundred cases. This was estimated to be only about 6% of the total number of feeble-minded in the state needing institutional care. In other words, it was estimated that there were about twenty thousand feeble-minded individuals in the state needing institutional care, but instead at large in the community, a chronic danger and burden to the community. It was also estimated that there were as many again (around twenty-one thousand) individuals in the state who were feeble-minded, but who nevertheless did not need institutional care. The total estimated number in the state of insane, feeble-minded, and epileptic, in institutions and not in institutions, was estimated at 59,000, or about 2.2% of the general population. Indiana had, it should be added, a population of about two million seven hundred thousand at the time of the investigation.[1]

These figures can be considered only as suggestive. Such field investigation is very difficult; satisfactory investigation of cases is often impossible; cases are often missed by the field worker, even when thoroughgoing inquiries are made with regard to the cases to be suspected as, in one way or another, defective. The figures given above are probably fairly conservative. A considerable number of surveys of this general nature have been made or are now in progress [2]—the findings

[1] It should be mentioned here, perhaps, that not all cases needing institutional care but not receiving such care were at large in the community. A very large proportion of the inmates of county poor farms were found to be mental cases. Such cases were found in the jails. They were traced to reformatories and penitentiaries. All such instances, of course, were emphatic evidence of the seriousness of the problems presented by mental disease and defect. . . . It should also be added that jail and poor farm do not give such cases the care they need—nor does the usual penitentiary or "reform" school.

[2] See, for instance, Rosanoff, A. J., *Survey of Mental Diseases in Nassau County*, New York, State Hospital Press, 1917, p. 125; Mental Hygiene Council of the Public Health Federation, *Mental Hygiene Sur-*

are usually substantially similar. Confirmatory evidence regarding these general conclusions has recently come from a number of sources. Thus the study of the results yielded by the draft during the war has indicated that about 6.5 individuals, per thousand men of the ages covered by the draft, are feeble-minded.[1] If we may suppose this proportion to hold for the total population, we may suppose a total of 700,000 feeble-minded individuals in the United States—outside of institutions. As a matter of fact, the number is undoubtedly greater, since mortality among the feeble-minded is higher than among the total population, and since the data from which the above-mentioned proportion was obtained omitted a few of the feeble-minded individuals between the ages considered.

The roughness of the various figures given above should be fully appreciated. As has been frequently emphasized throughout the previous chapters, criteria for diagnosis of the feeble-minded, and even the "insane" and epileptic, are very inexact and ill-defined. In fact, the differences are often differences of degree and it is impossible, often, to make any but an arbitrary division into even the two classes which have been considered in the above figures—the group of those who need institutional care, and the large group of the rest of us, who presumably do not. The results so far indicate only too clearly that the situation probably varies from one section to another, even from one community to another. In southern Indiana it is something of a byword that the feeble-minded are either "born, or come from Kentucky." Investigation of remote mountain districts in Kentucky and Tennessee has brought to light simply extraordinary conditions. There are whole communities made up of individuals who are to be considered, almost without exception, feeble-minded. But such communities can be found, the writers happen to know from personal experience, in Massachusetts and Indiana as well as in Kentucky. It seems quite clear, as the result of the

vey of Cincinnati, 1922, p. 131; Sandy, W. C., "Mental Defectives in New York State," *Mental Hygiene*, Vol. 4, pp. 380-92, April, 1920.

[1] Bailey, P., and Haber, R., "Mental Defect: Its Frequency and Causes in the United States," *Mental Hygiene*, Vol. 4, pp. 564-96, 1920.

psychological work done in the army, that all varieties of mental deficiency are to be found more frequently as one goes South—and progressively as one goes South, one finds poorer institutional care for defectives and less appreciation of the problem.

Frequency of Borderland Conditions of Mental Disease and Deficiency

Such facts and estimates as have been presented above bring home to one the realization that the problems of acute mental disease and mental defect are not incidental problems or problems remote from the average individual—problems that can be avoided (if not solved) by shutting up the unfortunates who thus suffer in institutions away off somewhere in the country. These matters are personal problems to a great many individuals; they are problems which no intelligent citizen can afford to ignore. But the various borderland conditions should have even more interest to the average person. The importance of the problems presented by the neuroses, by the various mild conditions of emotional instability, mental eccentricity, by subnormality, can hardly be overestimated. The writers venture the opinion that at least every fourth person in the general population goes through a neurotic episode around adolescence and would be the better for sound psychiatric advice. Many such individuals either develop a more or less chronic neurotic condition or accentuate certain constitutional tendencies so as to remain permanently lacking in vigor. There are few people who have not had a brush with a pathologically unstable individual, or been pestered at some time by a crank. The subnormals are even more common than the definitely feeble-minded. The constitutional psychopathic inferiors make up no mean group in the total mass of the economically inadequate. In short, borderland cases of all these various types are so numerous as certainly to be included among every one's everyday acquaintances.

The Mentally Abnormal in Society

The extent to which the mentally abnormal appear in major educational, social, economic, and industrial problems remains to be emphasized. The matter has already been touched upon in the first chapter. Here it is only necessary to stress again that the vast majority of the mentally ill and dwarfed are *not* in institutions (in fact, the large proportion should not be); the vast majority of these individuals are in everyday life, and the problems they present touch everyone. No statistics are needed to prove these points. Almost any public school teacher can testify from personal experience that there are feeble-minded children in almost every school and that they constitute a very serious educational (and often moral) problem. Any high school principal can tell of problems of mental health during adolescence, with which he has had to deal. As was mentioned in the first chapter, mental difficulties are not uncommon among college students, and constitute probably the most serious health problem in such institutions.[1]

Mental defect and crime are probably less closely related than was supposed a few years ago. By no means all criminals are mental defectives,[2] however, many court repeaters are either feeble-minded or dements, are psychopathic personalities, or exhibit other pathological mental conditions. In fact, the association between mental difficulties and criminal activity is sufficiently close that a study of all accused persons

[1] As a matter of fact a number of colleges and universities now have clinics or other arrangements for taking care of the mental health of the students. . . . These topics are further discussed in the chapter on treatment, where references bearing also on the extent of these problems will be found.

[2] See Murchison, C. S., "American White Criminal Intelligence," *Journal of Criminal Law*, Vol. 15, pp. 239-316, 1924, and "Criminals and College Students," *School and Society*, Vol. 12, pp. 124-30, 1920; Howe, C. P., "A Comparative Study of the Intelligence of 379 Inmates of the Indiana Reformatory and 653 men of the United States Army," *Journal of Criminal Law and Criminology*, Vol. 12, pp. 238-57, 1921; Doll, E. A., "The Comparative Intelligence of Prisoners," *Journal of Criminal Law and Criminology*, Vol. 2, pp. 191-97, 1920.

as regards mental health seems in many respects highly desirable, and has actually been partly provided for in one state.[1] And although the relation of feeble-mindedness to crime is being less stressed, it is becoming more and more evident that conditions of mental conflict are distinctly important in this connection, and that study of the personality of the offender is always worth while, and likely to be attended by constructive results.

Many social problems are so intimately related to conditions of mental disease or defect that it is impossible to discuss one without mentioning the other. The hobo is often a mental case. He is sometimes feeble-minded, sometimes more or less demented. He is likely to be pathological mentally just as he is pathological socially; he is evidently unable, for some reason, to adjust himself to the complex social life about him and so withdraws from society and effects an adjustment—more or less satisfactory—to the much simpler life of the road. The persistently unemployed are likely to be unemployable because of mental inadequacy or temperamental idiosyncrasy. Many investigations have been made, from this point of view, of prostitution. Here, as was the case in studies of the criminal, there seems to be less mental defect than was at first supposed. It is especially important to remember that it is only the lower class prostitute who is usually caught. But it is clear that many of these cases are mentally defective and that many others cannot be considered temperamentally normal. More and more, cases of sex delinquency are found to have their origin in abnormal home conditions which developed, or at least exaggerated, unfortunate emotional traits.[2]

[1] See Glueck, S. S., "Mental Examination of Persons Accused of Crime," *American Review*, Vol. 3, pp. 336-46, May-June, 1925. Studies of delinquent groups have been so numerous as to make it hardly possible to cite any particular references as outstanding. Readers interested in criminology will find a fair proportion of this literature in the *Journal of Criminal Law and Criminology*, *The Journal of Delinquency* and in *Mental Hygiene*. Healy's *The Individual Delinquent* is a classic book in this field.

[2] For further contact with these topics, see, for example: Anderson, N., *The Hobo*, University of Chicago Press, 1923, p. 302; Solenberger,

Problems of mental health in industry have been least adequately studied. It is fairly clear that one problem of employment management is the placement of workers in positions suited to their ability, that subnormal individuals can get along in industry if given simple routine work, that much industrial unrest is due to maladjustment of work to intelligence. However, these matters constitute only one relatively preliminary element in the total problem of adjustment of the worker to his work. There appears to be a great need for mental hygiene service in industry. The worker who becomes inefficient may be a case of neurasthenia due to an emotional crisis which might be readily solved with a little outside help; the quarrel between two valuable skilled workmen may be evidence of pathological temperament in one of the workers, the attack of one workman upon another may be an epileptic equivalent. Though relatively little information on the subject has as yet been accumulated, there is still some evidence (as was mentioned in the first chapter) to show that problems of mental health in industry are decidedly important—perhaps the most neglected of all the larger problems of employment management.[1]

In considering the extent of mental disease and disability, the following facts are, then, to be kept in mind: (1) There are at present over 300,000 individuals in institutions for the mentally diseased and defective in this country. (2) It is probable that there are many more cases who need institutional care but are nevertheless at large in the community. (3) The various borderland conditions of mental disease and

A. W., *One Thousand Homeless Men*, Russell Sage Foundation, 1914, p. 373; Mateer, F., "Prostitution," *Psychological Bulletin*, Vol. 17, pp. 410-17, 1920.

[1] See, for instance, Southard, E. E., "A Movement for a Mental Hygiene of Industry," *Mental Hygiene*, Vol. 4, pp. 43-64, January, 1920, and Jarrett, M. E., "The Psychopathic Employee: A Problem of Industry," *Medicine and Surgery*, Vol. 1, pp. 727-41, 1917.

deficiency are so common as to be met by every one. (4) Many outstanding educational, social and economic problems are largely problems created by the presence in the community of mentally abnormal or defective people.

CHAPTER XIII

THE CAUSES OF ABNORMAL MENTAL STATES (ETIOLOGY)

In discussing the various disease entities, much has already been said with regard to the conditions out of which mental abnormality develops. Something remains to be said, however, as to the comparative importance of the various causative factors and the ways in which they may be supposed to interrelate.

The Distinction between Predisposing and Exciting Causes

It will be found valuable, in the first place, to distinguish between predisposing causes and exciting causes. As has been pointed out in the previous chapters, consideration of a case frequently carries one back to the supposition that a hereditary nervous weakness must be the fundamental factor in making possible a mental upset. Heredity in such an instance may be considered the predisposing cause. However, the outbreak does not come until a time of stress makes the weakness apparent. An unfortunate love-affair, we will say, so disturbs the patient that he goes to pieces mentally. As love-affairs do not ordinarily so operate, we may suppose the hereditary weakness the fundamental pre-condition, which made the collapse possible. But without the love-affair the collapse might not have come—at least, not at that particular time. The love-affair is, then, the exciting cause.[1]

[1] The reader in doubt as to the distinction should go back over some of the case studies with this topic in mind.

It might seem that this distinction did not apply in studying the

The concept of the predisposing cause may seem to the reader somewhat unusual—and rather discouraging. The concept, however, is of great importance also in the study of physical disease. Liability to tuberculosis seems more or less hereditary. Resistance to physical stress appears to be thus inherited, and various sensory deprivations. And though these predispositions can hardly be readily modified, still, since there are only a few predisposing causes, the attack upon these can be centered and real progress expected, once the movement for "mental hygiene" gets well under way.

Predisposing Causes

First with regard to the predisposing causes. Four important causes may be listed. First is hereditary nervous instability or weakness. Such hereditary taint may be supposed the great factor in the causation of feeble-mindedness; the feeble-minded are primarily a problem in eugenics. A hereditary factor is also usually found in the families of individuals suffering from manic-depressive psychoses. In fact, it is asserted that evidences of some sort of family taint may appear in a very large per cent of the cases; and it is frequently stated that manic-depressive insanity is not to be considered simply a disease which "comes upon" a patient, but as something which comes out of a temperament colored by the manic-depressive characteristics. The individual is, throughout life, characterized by a certain melancholy, a certain exuberance, or a somewhat periodic fluctuation of mood. Dementia præcox also appears, in many instances, against the background of a family markedly atypical. And as has already been mentioned, the individual is likely to show from child-

feeble-minded; there would seem to be, in such cases, no exciting cause. Even here, however, it is often profitable to distinguish the underlying incapacity and the particular set of circumstances which brought about the crisis—the criminality, economic failure, or other difficulty. Fundamentally, the exciting "cause" simply makes evident the condition in such instances. However, in many cases of mental disease the exciting cause does little more.

hood a peculiar shut-in type of personality, and a certain retardation in mental and physical development, which are often suggestive of some constitutional lack. Epilepsy appears to be largely hereditary. And the great group of borderland conditions—the psychopathic personalities, the strikingly neurotic, the paranoidal—all frequently seem to find only in the family history an adequate explanation.

Heredity thus plays a very important part as an explanatory factor in the study of mental disease and disability. But other physical factors are also of great importance. Deserving of first mention is syphilis. Syphilis is quite clearly the cause of general paresis and of various related neuro-syphilitic conditions. The proportional importance of this factor may be inferred from the fact that over 10% of admissions to state hospitals are directly traceable to syphilis. It should also be mentioned in this connection that many conditions *not* directly traceable to this disease are nevertheless very likely of syphilitic origin. Syphilis is frequently, in cases of cerebral hardening of the arteries, a very important background factor in the situation. Juvenile paresis is due to congenital syphilis. So, often, are cases of feeble-mindedness. And it is quite possible that syphilis in the parents may result in a certain nervous weakness in the children, even where more specific traces of the disease are absent.[1]

Alcohol deserves next mention. Fortunately, alcohol is not (as was indicated in the previous chapter) operative in producing intellectual debility to the extent that it once was. But it is well worth recalling that between 10% and 15% of admissions to state hospitals used to be traced back directly to alcoholic excess. And experience in other countries shows that the percentage here was by no means as great as it might have been. Alcohol and other drugs may be supposed in

[1] The conditions catalogued above do not, of course, involve diseases nervous rather than "mental." As a matter of fact neurological clinics are to quite an extent syphilitic clinics. Tabes is a relatively common disease. The importance of syphilis from the point of view of mental hygiene cannot be overemphasized.

the aggregate to have accounted for no mean proportion of all the cases of mental breakdown.

One more very important (possibly most important) predisposing cause remains to be mentioned. It has been suggested that in dementia præcox we may have not so much a disease as the essentially inevitable product of a morbid personality, bound, sooner or later, to collapse under inadequate social adjustments. And it has been intimated that the morbidness of mental make-up may be essentially an hereditary matter. However, more recent views suggest that other factors may play an important part in the development of this inadequacy —perhaps even develop such a morbidness in a nature originally healthy. It appears that many cases of the neuroses and of the functional psychoses are cases where fundamentally vicious habits of thought and emotional attitude, developing since childhood and involving repressions most commonly of a sexual nature,[1] play a very important part in producing the morbid condition. Such habits, we may suppose, develop most easily in psychopathic soil. But these conditions, primarily of psychogenetic origin, these bad habits and suppressed ideas, appear capable of developing even where the constitution is relatively healthy. There is first an unfortunate attitude in early childhood toward some sex problem, then the acquirement (through poor parental handling of the situation) of a suppression and morbid interest, then a loss of self-respect and (in connection with this) an isolation from free companionship with other children. The whole situation is tense and unhealthy. Finally, in adolescence or in adult life, the situation comes to a climax in connection with some emotional stress, an attempt at a work which is overtaxing or, particularly, emotional difficulties of a sexual nature. And there is that psychic disintegration which is called dementia præcox—

[1] It is probable that the sex factor has in the past been exaggerated. In many cases the fundamental difficulty is a matter of social adjustment in which sex is (unless the word is used in a very broad way) relatively unimportant. Often a sex crisis precipitates the situation and so makes the sex element appear more important than it is.

the emotional invalidism which is the neuroses—or some such outcome. . . . Just how important such psychogenetic factors are it is impossible now to say. However, the tendency of present investigation seems to be toward the greater and greater emphasis upon these factors.

It should be appreciated that what appears to be hereditary taint in a family may actually be nothing more than the operation from one generation to the next of these psychogenetic factors. Some unhappy experience may develop in an individual a morbid repression and excessive irritability, or some such persistent peculiarity of character. If, now, this individual marries and has children, his personality may give its tone in large measure to the family life. And the children may develop similar attitudes—perhaps more marked since these influences began to operate in *their* lives from the very beginning. And so there may be transmitted from one generation to the next certain anomalies of personality which begin to make their appearance very early in life and in almost every respect seem to have their basis in constitutional peculiarities. But actually they may be due to what might be called a "social heredity."

It is also important to notice how society often conspires to increase and establish the influence of any such conditions. Thus if some unfortunate experience develops in a man a hatred of the church and he becomes known in the community as an atheist, he may, in a conservative community, be more or less shunned. It is likely that conventional mothers will warn their children not to play with the children of "the atheist" (the writers have known of such cases). It is very easy under such circumstances for the children to develop a neurotic or paranoid temperament. If a parent has a criminal record, this sort of thing may quite easily happen.

Last of all, it should be mentioned that evidences of mental defect may be accentuated in analogous fashion. If the parents are shiftless the children early acquire shiftless habits. They are looked down upon by other children and may react by a surliness which may later lead to criminal acts or by a hopeless attitude which accentuates the original incompetency. Further, the social and economic status of the family more or less sets the standards toward which the children try to work; if these standards are low the children have much less incen-

tive to educational or economic efficiency than would otherwise be the case. The important point here is that criminal acts and industrial incompetency may not be so fundamentally related to feeble-mindedness as appears from the frequency of the association.

The four most important predisposing causes are, then: (1) heredity; (2) syphilis; (3) alcoholism; and (4) morbid emotional development. It must not be thought that this exhausts the possible list of predisposing factors. Malfunctioning of one or more of the ductless glands is the well-recognized cause of certain peculiar conditions of defect and of psychosis, may be the important element in various obscure conditions of emotional instability, may be the important physiological product in the psychogenetic conditions. Long continuing focal infections may in some cases be the major background factor. Head injury may be supposed the important etiological factor in the development of psychosis in a few cases—less than 1% of first admissions. But the four cases first mentioned are the most important, so far as definite knowledge goes at present. It must not be thought, either, that in studying a case the etiological analysis is completed if one of these factors is found to be present. As has just been mentioned, the functional psychoses, even though they may be the result of a morbid psychogenetic development, are likely to develop out of a constitution inherently somewhat unstable. Chronic alcoholics are very often alcoholic because they are feeble-minded, because they are depressed and wish to avoid emotional difficulties or are in the excited phase of manic-depressive insanity and crave excitement, or because they belong to the group of the constitutionally unstable, with lack of self-control as the cardinal symptom. Sexual excess and syphilis also come easily to these unstable cases or to cases in a manic episode. The moral dilapidation of the dementia præcox may show itself in both alcoholic excess and sexual indulgence. In fact, we may very well have a case constitutionally unstable, as a result a chronic alcoholic, who early develops syphilis and

ends up with general paresis and a clinical picture of excitement, alcoholism, and paretic dementia. It is worth noting that poor heredity, in this way of viewing it, is the great common factor. But it can easily be made too much of.

A variety of other contributing etiological factors remain to be mentioned as of some interest, though of less importance. Apparently, *race* plays a part in determining the type of psychosis which an individual may have. The Irish tend most to be alcoholic. The Jews are more likely to suffer from such functional psychoses as dementia præcox and manic-depressive insanity. Negroes are most likely to have general paresis. It is interesting, however, to know in this connection that when all special factors are allowed for, the immigrant population appears hardly more troubled with insanity than the native American stock. This does not mean that every effort should not be made to keep out the feeble-minded and insane immigrant, of course. The findings do indicate that our immigrants are not overburdening our state hospitals to the disproportionate extent that has sometimes been supposed.

About double as many admissions to state hospitals come from urban as from rural populations. However, the situation is again complicated by the fact that there is a greater proportion of adults in the cities, a greater amount of alcoholism and venereal disease in the cities, and so on. It appears, after discounting for these various factors, that there is probably little difference between the rural and urban populations in the incidence of mental disease. The same special factors operate to produce apparent sex differences. There are more men than women in institutions. But this is apparently due to the greater prevalence of general paresis and alcoholism among men. When these two diseases are eliminated from the tables, the sex differences largely disappear.

Nearly four times as many illiterates are in institutions as literates, in proportion to the total number in each group in the general population. It is not to be concluded that education is a preventative, however.[1] Rather, the same cause, degenerate stock, made these illiterates incapable of acquiring an education. There is somewhat the same twist to the argu-

[1] There is on the contrary some evidence to suggest that the usual bookish type of education may lead away from healthy contact with reality and toward mental instability.

ment, if one asks whether marriage may be conducive to sanity. Insanity is more common among single individuals. But these figures are probably best interpreted as meaning that the insane—potential or actual—are somewhat less likely to marry. Their single state is one more bit of evidence of their peculiarity. There appear also to be differences so far as occupations are concerned, differences doubtless to be interpreted after somewhat the same method.

Age is a factor of more importance. The incidence of insanity sharply increases with advancing age. Moreover, the age offers help in making the diagnosis. The senile psychoses rarely appear before sixty. Involution melancholia is hardly to be looked for before forty. Half the cases of general paresis appear between thirty and fifty; the onset of more than half the cases of dementia præcox and manic-depressive insanity is before thirty.

Exciting Causes

So much for the predisposing causes—the background factors from which pathological mental cases develop. Exciting causes are numerous and usually much less important. They are likely to be much more obvious, however, and often receive more attention than they deserve.

A predisposing cause may, of course, also operate as an exciting cause. A case of alcoholic hallucination may be precipitated by a prolonged spree. Or that same spree may be—at least associated with—the beginning of general paresis. Perhaps the patient may have a complex episode where he has a drunken fall which injures his head and which initiates active paretic symptoms. In some instances, the predisposing cause may seem to be self-sufficient; there is no distinct exciting episode worthy of mention. Thus general paresis develops in its own good time without the aid of any facilitating circumstances. Alcohol usually needs no help from without. Dementia præcox may appear no more than the flowering of the original morbid disposition or may be the inevitable outcome of the vicious habits, one important circumstance being that there is *no* change in circumstances which might break up the morbid mental attitudes. In many cases the apparent exciting

cause is astoundingly trivial. The writers know of a dementia præcox case which appeared to take its origin from an exceedingly mild housekeeping accident in which the patient pinched her finger in the icebox door. A factory worker also developed præcox apparently as the result of a slight flesh wound in the arm from a flying bobbin (however, in this case, it should be mentioned that there was considerable emotional agitation in connection with the suit for damages under an employers' liability act).[1]

Two types of exciting cause deserve special mention. In the first place, a sudden physical weakness or exhaustion gives opportunity for any morbid mental condition to show itself; particularly a hemorrhage or an accident may figure prominently. The stress of childbirth may so operate. However, it is as an exciting cause that psychic factors come most clearly into the situation. The more intimate investigation becomes the more it appears that acute mental difficulties are likely to be associated with times of emotional stress. Very often physical disease or accident appears thus to operate rather more than as a physical cause. So childbirth is more likely to result in mental difficulty if the child is illegitimate. Or, as in the case of the slight wound above mentioned, accompanying emotional stress is the more important factor in the situation.

Such complications of physical and mental strain are especially likely to occur in case of head injuries. There is also this complication in connection with physical conditions due to age. Thus in the senile and presenile conditions and at the involution period there are important physiological changes and a general lessening of the vitality—perhaps profound changes in the total physical economy. But this is not all. The advance of old age is hardly pleasant to contemplate in any case. These physical changes accentuate the fact of the passing of physical vigor; and a not unnatural result of the whole situation is a morbid mental and emotional condition.

[1] This last complication may operate extraordinarily. A case of "traumatic dementia" may largely clear up after a cash settlement.

The Responsibility of Society

It remains to be pointed out that, more or less directly, society as at present organized is a major cause of many of the abnormal conditions discussed in Part II. At least, society is responsible for the circumstances which have made possible the development of these abnormal conditions. Such responsibility society has acknowledged as regards use of drugs; and it is gradually coming to take the same attitude toward alcohol. Society is just as much responsible for the present ravages of syphilis as it would be for the results if there were no attempts to control smallpox or typhoid. Society regulates marriage in certain formal ways; it is responsible that the marriage of defectives is not prohibited and the total of defective stock in the world decreased, by at least an elementary consideration of eugenic principles.

Society is responsible for abnormal mental conditions in other ways that are somewhat more subtle. In most cities there is little or no provision made for healthy recreation; the boys and girls, therefore, find themselves forced into artificial, unhealthy modes of amusement—modes which frequently result in a very real maladjustment to their environment. City life also provides, for many children, an injurious overstimulation, The miserably crowded home conditions which exist in many cities not only sap physical strength but (in the emotional sphere) exacerbate difficulties of adjustment and make critical any inadequacies of personality. The great cities are gradually developing a conscience for such conditions. Economic distress and unemployment bring mental stress; a better organized society would not permit these economic maladjustments.

Society is responsible in still other respects. The traditional education does not train for sanity but (as already mentioned) tends rather in the other direction; it often cramps and represses the child's nature, may substitute verbal formulæ for the real facts of existence. Last, but by no means least, society

is responsible for the numerous unfortunate pseudo-moral "taboos," reserves, and superstitions which do so much to bring about the morbid repressions and emotional conflicts at the back of an astounding amount of mental, emotional, and even physical ill-health. In short, men and women are social beings and their mental difficulties are largely products of the society in which they live—are, indeed, evidences that that society is not organized as it should be.

There are, then, three main points to be kept in mind in considering the causes of mental defect and disease. (1) Back of any present condition of emotional difficulty one should look for certain predisposing causes making the individual susceptible to stress. Inherited nervous weakness, syphilis, alcohol, and other drugs, and anomalies of emotional development are especially important influences predisposing to mental difficulty. (2) The individual already predisposed is finally brought to overt mental ill-health by some exciting cause. The most common exciting causes are emotional shock or strain and markedly impaired physical condition. (3) It is to be noted that the majority of the influences that bring about mental difficulty are under the control of society and come from conditions for which society is very largely responsible.

CHAPTER XIV

THE TREATMENT OF ATYPICAL MENTAL CONDITIONS

Treatment of Predisposing Causes

In the previous chapter the distinction was made between predisposing and exciting causes. In the present chapter a distinction is, first of all, to be made between treatment to remove a cause and treatment of symptoms. Evidently the most fundamental treatment would be directed against the predisposing causes. Evidently, also, such treatment is difficult! If a case has a poor heredity that heredity can hardly be improved by medication or otherwise; and (as was emphasized in the previous chapter) poor heredity is frequently the pervasive background factor, even where other causes appear to dominate the situation—as, for instance, alcohol. For the individual's innate constitution one can do essentially nothing.

At present practically nothing can be done for the general paretic. Such drugs as salvarsan and neo-salvarsan appear to have little or no effect.[1] The chronic alcoholic can, of course, be kept from alcohol—with difficulty. He is still likely to get the stuff (unless he is feeble-minded) now. It should be granted at once that the nervous system appears to have a surprising capacity for recovery from the effects of alcohol; cases of alcoholic dementia may improve remarkably. But good intentions are likely to be out of proportion to will-power. It might almost be said that, if the patient could not resist alcohol in the first place, he can hardly resist the temptation now that he has been weakened by continued indulgence.

[1] As was mentioned in the discussion of paresis in Part Two, however, recent work on the problem promises greater success.

So much for the first three prime predisposing causes.[1] There is inherent in the psychogenetic theories the possibility of a real therapy for the various functional conditions. These newer theories have been, as yet, perhaps too little developed under constructive criticism to permit any very positive assertions. But it would seem that in a fair proportion of cases, at least, a reëducation, or a reconstruction of the situation, was possible, which not only eliminated the difficulties of the immediate crisis but built up the individual to a better withstanding of later times of stress.

Very often the "treatment" is really most obvious, once adequate study of the individual's history and present circumstances has been made. The source of the mental illness may be an impossible home situation; simply removal from the home to a different social environment may do wonders. An actual prostration, involving many physical symptoms of an apparently alarming nature [2] as well as evidence of emotional trouble, may go back to a misunderstanding between husband and wife which is easily cleared up by an impartial third person (the psychiatrist); complete recovery then quickly follows. Adolescent episodes may be entirely disposed of once a youngster's mind is relieved by accurate sex information in place of street talk or quack literature. A young man with a very odd and ludicrous physiognomy, about which he is so sensitive that the peculiarity actually leads to a psychotic episode, may learn to make social capital out of his handicap, as a comedian.

However, the important causes of these functional disorders do not often lie on the surface. And modification of the emotional situation by some relatively simple change in the physi-

[1] In the previous chapter, it was mentioned that glandular disorder, focal infection, or other obscure physical conditions might be the major causative factor, in many instances. Evidently careful physical examination, with such possibilities in mind, is always desirable. And when such factors are found, treatment should be directed first of all to their elimination.

[2] Such cases are not infrequently operated upon by misguided or avaricious surgeons for physical ills which may be thus simulated.

cal or emotional environment is often either not possible or not effective. A very painstaking search for hidden sources of emotional anguish, and a scarcely less subtle process of emotional readjustment, are then necessary.

The methods here usually employed, and the concepts back of them, are really, after all, simple enough. The notion is of an emotional conflict resulting in a final emotional disintegration. The effort is at a resolution of the emotional difficulty and a harmonious organizing of the individual's emotional life. In undertaking such an investigation into an individual's inmost secrets, it is obvious that the utmost patience and tact are necessary. To gain the patient's confidence, it is usually desirable to make every circumstance conducive to a confidential revelation, on the part of the patient, of his difficulties. A quiet room, perhaps darkened, and free from distracting influences, is desirable. The patient is, perhaps, asked to lie down on a couch, to relax both physically and emotionally so far as possible. The doctor then begins that quiet but persistent inquiry with regard to the patient's emotional difficulty which is, essentially, "psychoanalysis." In the course of this analysis, the effort is particularly to get at any suppressed emotions which may be causing the patient trouble, because of the conflict between these desires and moral scruples, morbid reserves, or other factors acting as a "censor" to suppress these desires—usually of a sexual nature. The effort is also made to go back into the patient's early life, even into early childhood, as far as possible.

Usually, the patient is very loath to reveal these hidden desires; the "censor" protests against their revelation even to the physician. It is the function of the psychoanalytical technique to bring the patient to the point where he is willing to release his inmost secrets; the darkened room, the relaxation on the couch; the quiet, even, sympathetic voice of the physician, all combine to bring the patient to the point where he is willing to talk freely. Certain artifices may help. The doctor may stroke the patient's brow, assuring him meantime that now he will "remember" the details of the emotional episode he is unwilling to describe. Possibly the doctor may develop these special controls further, obtaining the fixed attention of the patient to the point where he is hypnotized—though hypnotism is now used practically not at all.

An understanding of a case can usually not come except after a considerable number of such intimate interviews; and it should be said in fairness to the patient that, very often, he really cannot remember the ideas which he has suppressed; the repression has been so complete that the patient's own best efforts do not suffice to recall the affair. Under such circumstances, the physician tries to piece together the situation as best he can and to aid by a hint now and then, in the reproduction. (And it should be mentioned in this connection that the overzealous psychoanalyst may insinuate into the patient's mind, by his suggestions, incidents which never happened!)

Finally, the difficulties are revealed. Perhaps it is a story of early masturbation, which has now aroused very distressing misgivings as to sexual health, in connection with contemplated marriage. Possibly some more or less accidental childhood sex episode involving a sex practice of a somewhat "unnatural" character has been the beginning of the morbid emotional development. Perhaps the difficulty has little apparent relation to sex, but is connected instead with some early humiliation which has placed the patient in a strained and possibly degrading relation to his companions. But in any case the fundamental feature of the difficulty is that the emotional conflict has operated like a festering disease, to poison the whole mental life. And it is the problem of the psychoanalyst to open the old sore, drain off the poisonous matter, and heal the old wound. This he must do, first of all, by revealing to the patient the true nature of the difficulty and bringing to the sufferer an understanding of the situation. The patient who is troubled about early masturbation must understand that such habits are common, usually do very little harm, and need not be worried about, or interfere with future plans. Much the same comforting statements may be made to the individual regarding childhood sex experiences. An understanding of the difficulty, a release and "catharsis" of the suppressed emotion, is the first necessity.

After this must come a certain process of reëducation. A certain hardihood, a larger understanding of one's self, a greater self-confidence, a broadened and more cosmopolitan attitude toward other people, must be brought about. That is, the psychoanalyst is engaged in the process of rehabilitating and redeveloping a character. The process is a long and tedious one, permitting never the slightest deviations from tactfulness

and sympathetic understanding, and requiring an unusual knowledge of human nature in both its best and worst elements. But remarkable results appear to be produced in many cases. And—more important still—an understanding of the most profound nature, with regard to certain hitherto unknown elements and mechanisms of character development, is being obtained. It should be obvious, however, that this sort of thing is not for the amateur to trifle with. The first probing and searching into the individual's past life, and opening of the old sore, might be described as a bit of psychic surgery; and unprofessional attempts at such operations might well be labeled as a very serious bit of malpractice.

So much with regard to the treatment of these major causes. Looking at the thing in the large, one must admit that, often, not much can be done.[1] This does not mean that the situation is impossible. The study of mental pathology is really only in its beginnings. Once there is more general acquaintance with what is at present known about this whole subject, the situation will be much improved. Now, the family do not understand how to coöperate in treatment; neighbors and friends often, with the best of intentions, do just the wrong thing. All too often a case is not seen by an expert until the difficulty is of long standing and treatment thus difficult.[2]

[1] One can, of course, experiment more or less blindly in dealing with the various mild or borderland cases. Change of environment may be recommended, or recreation, or rest, or a different kind of work, or a hobby, or travel, or seclusion, or society and diversion—there are a hundred and one possibilities. And if a doctor is retained at a good fee, he may experiment with such recommendations, and may make the patient better, if he does not make him worse. But this sort of thing is not treatment; it is simply experiment. And one of these changes may be desirable because of the nature of the emotional complex; but the recommendation should be based upon such thorough understanding of the case as can come only with intensive study and with a wide knowledge of mental difficulties. Change of environment should not be recommended offhand as a cure-all for mild mental affliction.

[2] Most people dread exceedingly sending one of the family to a hospital for the insane or otherwise recognizing the case as a problem of mental disease; so the case never gets to the psychiatrist for treatment until an acute condition has developed. It is generally recognized, at present, that this dread of a hospital for mental diseases must somehow be got rid of. So out-patient clinics are being established for the treatment of cases suffering from mental disease. It is possible for a family

Treatment of Exciting Causes

Treatment of incidental, exciting, and contributing causes need be touched upon only briefly. Two exciting causes were especially mentioned—physical and emotional stress. Physical conditions resulting from wounds, accidents, or disease naturally receive their proper treatment in any general hospital. The mental difficulty complicates the situation, in making the patient less coöperative in treatment of the physical condition and (very often) in bringing about an excitement which further exhausts the patient's strength. Special emotional stresses (the second important exciting cause mentioned in the previous chapter) can be dealt with constructively in many cases if the total situation is thoroughly understood, and time is available. It must be kept in mind, however, that treatment directed with reference to an exciting cause may do little more than postpone a grappling with the real problem. As can be inferred from what has been said previously, this is especially likely to be

to have one of its members visit such a clinic without so much as entering the hospital itself, to obtain advice with regard to simple matters of treatment and mental health. Above all, such clinics give an opportunity for the patient and his family or friends to come in contact with those making a specialty of handling just such mental difficulties, and to acquire the medical instead of the religious and superstitious attitude toward mental derangement. The clinic may then, in many ways, facilitate the transition into a psychopathic hospital, if hospital treatment is desirable. In many instances, it should be said at once, hospital treatment is not either necessary or to be desired. Nothing more than occasional visits to the clinic are necessary.

If the individual is to have care in the hospital, an arrangement by which the patient may come as a voluntary patient is most desirable. The old rule, by which a patient must go through a process of legal commitment in order to obtain hospital care, was exceedingly unfortunate. Out-patient clinics and provision for voluntary admission to a hospital for nervous and mental disease are, then, two features developed recently which have great promise. After a little while (if there is the clinic and the possibility of admission to the hospital in this easy way), cases begin to come for treatment while still in the incipient stages of their disease. Individuals with mild cases of the borderland type appear. The public is gradually educated with regard to mental and nervous trouble. The psychiatrists learn more about the incipient and borderland conditions. And the cases are seen early enough in the progress of their difficulties for treatment to have some effect.

the case where the exciting cause has been physical; the association between mental difficulty and physical stress may be sometimes hardly more than coincidence. When the exciting cause has been emotional, treatment only of the immediate problem may still be superficial.

Thus a hysteric (described in Part II) developed a hysterical paralysis of the left arm. It was finally discovered that she had been writing letters to herself—letters purporting to come from an admiring man—the writing being done with the left hand. When this situation was revealed the paralysis shortly disappeared. But the underlying difficulties—an inadequately organized emotional nature and a big city environment which starved her socially and gave no opportunity for normal healthy companionship with the other sex—remained essentially as before. Other episodes were to be expected.

The Care of Abnormal Individuals

The discussion has so far been primarily with reference to the carefully planned treatment of the psychiatric expert, dealing with a case intensively over a period of time. In the crowded hospital for the mentally diseased other procedures are practically a necessity. Treatment in the average hospital is, for the most part, a very obvious and immediate treatment of *symptoms*. The excited patient must be calmed; the patient who refuses food must, nevertheless, be nourished; persistent insomnia must be dealt with somehow. Excitement, in the old days, was handled by means of a straight-jacket or a padded cell—or the manic might be left to wear himself out with the vague notion of letting nature take its course. Nowadays the effort is to quiet the patient, to bring him to the point where he will rest and recuperate and regain physical and mental health again. Rest in bed is most desirable, if possible—is excellent for any condition. If the patient is too excited to make this possible, prolonged baths may be resorted to; the patient is kept in a soothing bath of water at body temperature, for hours at a time. At first the manic may find

the situation decidedly amusing, and may take great satisfaction in splashing any attendants or doctors who come near. Gradually, however, his activity becomes merely verbal, and something approaching "rest" becomes possible. Treatment of depressed cases requires constant vigilance to prevent self-destruction; otherwise one may find, some morning, that he has no patient to treat.

The ingenuity of would-be suicides is astounding. The writers knew of a man who asked his wife to bring him a can of tobacco and then, using the cover as a knife, managed to hack up his wrist so that he nearly bled to death before the blood soaked through the covers sufficiently to call the attention of the attendant. Other cases will manage somehow to fix the window frame so that they can suddenly jump out headlong when no one is looking. And lacking the means of actual self-destruction, they may run headlong into the wall or try a thousand and one ways of self-injury. Such patients will strangle themselves with the bedding, hack at their throats with a table fork, do anything to escape from their misery.

The patient's physical health must also be very carefully watched. Diet is important. Constipation is an invariable accompaniment of depression and melancholia, and every effort must be made to keep the digestive tract in some sort of condition. The patient is also sure to lose weight during the depression; one of the surest signs of approaching recovery is an increase in weight. Tube-feeding may be necessary in many cases because of refusal of food. The method is comparatively simple. A rubber tube is introduced through the mouth—or through the nose, if the patient clenches his teeth too badly to permit the introduction of a tube through the mouth—and a mixture of milk and eggs is then poured carefully down the tubing from a funnel.

Insomnia may be treated by the use of various drugs, if necessary. The patient's physical condition must constantly be watched, however. A variety of mental conditions put a great strain on the heart and make even mild drugging danger-

ous. In fact, the physical condition must be watched very carefully, in acute psychoses and in the chronic conditions. Intercurrent diseases must be guarded against; any epidemic which gets started in a state hospital is likely to result in a high mortality because of the low resistance of the patients. Pneumonia, tuberculosis, influenza, are always especially to be feared.

A word remains to be said with regard to the control of psychotic individuals. In the majority of conditions control is easy. In the beginning of the psychosis the patient is apt to be bewildered and frightened by his condition and very willing to be guided by any one in whom he can have confidence. The excited cases can often be managed surprisingly, simply by a quiet voice and an even, firm, undisturbed behavior. A sense of humor is essential; also a certain callousness—toughness, one might better say, sophistication, inability to be shocked, self-control, self-confidence, poise, and a certain "rough and ready" ability to meet people on their own level. And common sense is essential. There are certain conditions of epileptic or catatonic excitement where the one sensible thing to do is to have the patient either kept in a room by himself or tied up in a "cold pack." That is, the patient is wrapped up in a sheet which has been wrung out in cold water, and then wrapped up in a blanket (pinned with horse blanket pins) so that nothing more than his tongue can move.

Such treatment as has been described above may seem superficial. An individual is terribly excited, and he is put in a warm bath. Or he is so depressed that he tries to kill himself —and he is given a cathartic. Care of this relatively elementary sort is, however, obviously important; a patient must be kept alive, and in as good physical condition as possible. Good general care is a prerequisite for any more fundamental therapy. It is only unfortunate that the average state hospital does not have a sufficiently large staff, and is not brought into contact with most of its cases early enough, to make more fundamental methods either possible or profitable.

The discussion so far in this section has dealt with care of the psychotic (and with special reference to the functional conditions).[1] Most of the borderland cases are not cases which have to be cared for, in the sense in which that word is used above—the problem is rather a matter of adjustment in society, a topic to be touched upon shortly. However, some neurotics appear to need care of a somewhat similar nature; in fact, may importune it. And something the same methods apply. There must be development and maintenance of the best possible physical health. It is important to establish regular habits of sleeping, eating, and the other details of daily life. One must be watchful, however, not to indulge or develop hypochondria. And one must not become so devoted to the immediate problem of physical welfare as to forget that the major factor in the condition is probably of a very different nature.

After-care

It has been repeatedly indicated that an episode of a psychotic, neurotic, mild cyclothymic, or paranoidal nature, was ordinarily to be looked upon not as an isolated phenomenon, but rather as evidence of a fundamentally unhealthy emotional development, or marked instability of temperament. Under the circumstances it seems obviously inadequate to direct treatment simply with reference to this episode, and short-sighted to drop the case, once this particular crisis has somewhat subsided. Such action often does nothing more than return the individual—but in a weakened condition—to the very influences which excited the first outbreak.

Perhaps the most obvious examples of such blundering appeared in the handling of alcoholic psychoses, in the old days when such cases were very common. Thus a case of alcoholic hallucinosis might be brought to the hospital. After a short time the hallucinosis cleared up. The case was then dumped

[1] Care of the feeble-minded has been touched upon more specifically in Chapter X.

back into the world again, still weak physically and shaken emotionally by his experiences, and without a job. Very likely he had been a bartender or otherwise involved in the liquor trade. All his friends were so involved. Only in connection with the liquor traffic could he readily obtain a job. It was not at all strange that he should return to his old friends and his old work. And being still shaky in his nerves, it was not unnatural that he should have recourse, as he had previously, to alcoholic help. . . . A recurrence of the man's difficulties was almost inevitable. But surely he could not be greatly blamed.

Instead of thus abandoning a case once the acute condition has subsided, modern hospitals and clinics have developed carefully-thought-out programs of "after-care." In fact, the patient's sojourn in the hospital may be little more than the beginning of the efforts in his behalf. If the hospital has a social service, the first step upon the release of the patient may be to find him a suitable job in a suitable locality. The out-patient department will help in seeing to it that the individual maintains and improves his condition; he may be required to report at the clinic at stated intervals. He may also be visited occasionally by the social worker. He may be helped to make new friends. His interests may be directed toward healthy forms of amusement and recreation. In fact, if these various agencies of the hospital are what they should be, the patient may actually be better off after his hospital experience than he was before.[1]

[1] After-care is discussed above with reference to psychosis and the state hospital. The fundamental concept—of a guidance and care continuing after a crisis until the individual's existence has been firmly established again in habits of healthy emotional attitude and right living—is of obvious importance also in clinic work with the borderland, in dealing with the feeble-minded and delinquent. The following references will be found of interest in these connections: Gegenheimer, "After-care Work with Mental Patients from the Point of View of the Psychiatric Social Worker," *Mental Hygiene*, Vol. 8, pp. 778-805, 1924; Raymond, A., "The Placement and Supervision of Mental Defectives in the Community," *Mental Hygiene*, Vol. 8, pp. 535-47, 1924; Mencken, A. D., "The Rehabilitation of the Morally Handicapped," *Journal of Criminal Law and Criminology*, Vol. 15, pp. 147-54.

The Adjustment of the Abnormal in School, Industry, and Social Life

The question remains as to treatment of the great group of those who are not abnormal enough to come in contact with state hospital, school for feeble-minded, or court, but who nevertheless have problems of mental health and adjustment.

Systematic study of these matters is only in its beginnings. However, enough has been done to make clear the great value of such work—the truly remarkable things which can often be done. Such study has also gone far enough to show the tremendously complex and highly individual nature of these problems; here in particular is it true that no case is like any other and that any attempt at treatment must include consideration not only of the individual, but of his family, and the neighborhood and the total background from which the personality has developed. Since these problems are so highly individual it is difficult to give any adequate general treatment. Those interested on these topics are urged to follow up the references to be given shortly, and to learn from the concrete case studies, of which many of these references are largely composed, something more specific regarding the nature of the methods used.

For the school child there are, in general, two major problems of adjustment—adjustment to his home and to his school. And it must be confessed that study of problem children often leads one to the conclusion that the child usually does his part of the adjusting remarkably well; it is school and home which are stupid, unreasonable, morbidly suspicious, morbid in sex attitude, overemotional, and uncoöperative.[1] It seems clear from such studies that marked neurotic conditions may be developed in children originally entirely healthy nervously, by unfortunate school or home or neighborhood conditions; it even

[1] The writers are reminded of the principal of a private girls school who declared that her dream of happiness was, sometime, to be the head of an orphan asylum.

appears as though the functional psychoses might have such origins. It is also clear that such childhood maladjustments can often be entirely cleared up, if the whole situation is carefully studied, and handled with a reasonable tact, patience and understanding. It should not be necessary to add that the value of such treatment to the child, and to society, can hardly be overestimated.[1]

Methods of adjusting the subnormal have already been touched upon, and will be returned to in the following chapter. It is necessary here to say only that with early diagnosis of subnormality, placement in a class or section where curriculum and methods are adjusted to his ability and gradually lead to vocational training for such simple work as he is capable of doing, guidance into such work after leaving school, and provision for healthy recreation and some occasional general supervision, a feeble-minded boy may often grow up to be a self-supporting, self-respecting, and respectable citizen.[2] Modern study shows the delinquent to be very frequently a case of emotional maladjustment who is largely the product of unfortunate home conditions or related factors; and many of these cases are adjustable.[3] Many cases of social and economic difficulty due to mental abnormality can, apparently, be adjusted, and the abnormality itself made less serious and even largely reduced—again if there is adequate patience, tact,

[1] For an excellent concrete presentation of these matters the writers suggest Sayles, Mary B., and Nudd, Howard W., *The Problem Child in School*, New York, Joint Committee on Methods of Preventing Delinquency, 1925, p. 287. This reference deals primarily with children in the elementary school. Somewhat analogous work with high school pupils has been described by Bingham (Bingham, Anne J., "The Application of Psychiatry to High School Problems," *Mental Hygiene*, Vol. 9, pp. 1-27, 1925). Similar work with college students is dealt with by Doll and Leatherman in an article entitled "Maladjustment Among College Students," *Journal of Applied Psychology*, Vol. 8, pp. 390-410, 1924.

[2] See, for instance, Anderson, V. V., "A Study of the Careers of 321 Feeble-minded Persons Who Have Been in Special Classes and Are Now Out in the Community," *Journal of Psycho-Æsthenics*, Vol. 27, pp. 138-149, 1922.

[3] See, for instance, Healy, William, *Mental Conflict and Misconduct*, Little, Brown and Co., 1917, p. 330.

and understanding—by the social worker.[1] In short, the adjustment expert can often do extraordinary things in making minimal the consequences of mental abnormality—can in many instances materially help or even "cure" the borderland conditions.

Treatment of (1) the underlying, predisposing causes of mental disease and disability is then difficult. Hereditary weakness can hardly be modified. Little can be done when syphilis has affected the central nervous system. A personality once established in bad emotional habits is not easily changed. Treatment of (2) exciting causes appears often effective; but there are likely to be other crises, since the predisposing causes have not been eliminated. (3) Care of the abnormal is often both difficult and important. It is important, however, usually only because prerequisite for natural recovery or therapy; one should not feel satisfied if a "mental" case is receiving only physical care. (4) What is known as "after-care," or continuing guidance and help from the hospital or clinic after the crisis has been passed, is very important in reëstablishing a case in the best possible mental health. (5) Very much can be done for most borderland cases by persistent and intelligent efforts toward their better adjustment in the environment.

[1] See, for instance, Southard, E. E., and Jarrett, M. E., *The Kingdom of Evils*, Macmillan, 1922, p. 708.

CHAPTER XV

MENTAL HYGIENE

As things are now, it has been estimated that only about 5% of the cases admitted to state hospitals for the insane are finally discharged in a condition which can be considered a real recovery. That is, only one in twenty cases can be supposed to return to original mental vigor. Further, any "cure" of feeble-mindedness is not now thought of. Treatment of the borderland conditions is, of course, often clearly effective, and recovery more frequent. But the number of these mild cases who continue in a state of mental and emotional invalidism is appalling. If, then, treatment for these various conditions is so inadequate, and natural recovery thus exceptional rather than common, one naturally turns to a consideration of preventive measures, with the hope that mental disease and deficiency may perhaps be controlled, even though individuals once so afflicted cannot now readily be cured.

Early Ideas Regarding Prevention of Mental Abnormality

The general outlines of the situation are simple enough, and can almost be inferred from what has already been said with regard to causation. A few years ago great stress was put upon the necessity for the control of pathological heredity. The constitutional psychoses appeared to be inherited directly in many instances, and to be the result of a family taint of some kind in most of the cases remaining. A suggestive heredity was frequently found in the study of the organic psychoses. The inheritance of feeble-mindedness was strikingly, even dramatically, demonstrated. So a eugenic program appeared to be the one program adequate to deal with these problems.

It was pointed out that in earlier periods there was a rough and ready elimination of the mentally unfit. The feeble-minded were unable to maintain themselves and starved or died of disease, or otherwise perished. The depressed case found much less difficulty in destroying himself. The lack of all care for the mentally diseased led to their early elimination in the struggle for existence. The pathologically unstable came into contact with a brutal justice which was quite ready to eliminate those who were incapable of reasonable conformity with the fundamental laws. At present, on the other hand, every effort is made to keep alive both the physical and the mental weaklings, to save the mentally diseased from the natural consequences of their condition; the chronically criminalistic and irresponsible receive more than their proportional opportunity for reform. As compensation for the earlier biological selection, it was argued that a rigid control of selective processes by society was now necessary.

Various measures for such eugenic control were, therefore, proposed. Legal provision for the sterilization of the unmistakably defective was made, in some states. It became immediately obvious, however, that such measures were—at least, premature. Interest then centered upon the possibility of prevention of the continuance of defective stock by means of segregation of the defective. Only a few years ago this was the substance of the program. It was the hope that, finally, the great majority of the insane and feeble-minded might be placed in institutions. The institution, it should be noticed, was, from this point of view, not an agency for treatment and recovery, nor educative. The institution was primarily a means for bringing about the extinction of defectives. Somewhat incidentally—the institution removed the defective from society (in connection with this process of eugenical control) and so freed society from the possibility of criminal activities on the part of the defective. But the great function of the institution was to segregate the defective and prevent him from reproducing his kind.

It is now being realized that such a program is woefully inadequate to the situation. The feeble-minded are far too numerous to permit of such wholesale segregation. And the problems of mental disease and health are revealing themselves as altogether too complex and too pervasive to make solution by such crude methods thinkable. As a matter of fact, the whole situation is at present being radically reconstrued, and problems reformulated.

Control of Feeble-mindedness

The most advanced present-day ideas with regard to handling of the feeble-minded seem, at first thought, astoundingly at variance with the views of ten or fifteen years ago.[1] It seems to be fairly well demonstrated, from study of cases of feeble-mindedness paroled from the best type of institutions for the feeble-minded, that many feeble-minded individuals may well be returned to the environment, from an institution, after the institution has carried them past the period of adolescence. Such cases may earn an honest living, behave in a law abiding fashion; and (the important fact from the point of view of the eugenist) these cases marry less frequently than would ordinarily be the case, and usually lead a life which is sexually moral. Moreover, it appears that defectives trained in the public schools in special classes, and guided and guarded, vocationally and socially, into adult life, may also lead a law-abiding existence, and often be prevented from either marriage

[1] See, for example, Mathew, M., "One Hundred Institution-Trained Male Defectives in the Community under Supervision," *Mental Hygiene*, Vol. 6, pp. 332-42, 1922; Greene, E., "History of 79 Feeble-minded Girls under Supervision in the Community," same journal, Vol. 7, pp. 785-95, 1923; Anderson, V. V., "A Study of the Careers of 321 Feeble-minded Persons Who Have Been in Special Classes and Are Now in the Community," *Journal of Psycho-Æsthenics*, Vol. 27, pp. 138-49, 1922; Fernald, W. E., "The Subnormal Child," *School and Society*, Vol. 18, pp. 397-406, 1923; Bernstein, C., "Colony and Parole Care for Dependents and Defectives," *Mental Hygiene*, Vol. 7, pp. 449-71, 1923. The best presentation of the general point of view here advocated is probably to be found in Davies, S. P., *Social Control of the Feeble-minded*, The National Committee for Mental Hygiene, 1923, p. 223.

or sexual immorality. It is such supervised life in the community, rather than isolation from the community, which is being advocated at present as the most wise method of dealing with the great majority of the mentally inadequate.

Evidently such special treatment and guidance, over a long period of time, can be possible only when the public has been educated to a point where it is willing to support such measures. First of all, in fact, public opinion must be brought to consent to such somewhat wholesale social guidance. More particularly, parents must be educated to the point where they will coöperate in such special training and supervision. The contract is evidently a large one. There is involved a molding of public opinion which will essentially modify the problem of feeble-mindedness in its very essential features; for since the feeble-minded are a problem because of their relation to society, a different attitude on the part of society toward the defectives will essentially modify that relationship, and so tend to modify the significance of the term. The interesting feature of the whole situation is that, for the present, the problem is primarily educational; the public must be educated to the notion of social control to an extent never before dreamed of.

Control of Physical Factors Contributing to Mental Ill-health

Early notions of control of mental disease, chiefly by eugenic measures, are also being modified. In the first place, such factors as alcohol and syphilis clearly operate to produce a great number of abnormal mental conditions; further, syphilis and alcohol present great problems involving not merely mental disease but much more beside, and (the important point here) alcohol and syphilis appear much more possible of control than heredity. The immediate need is again for a general education in these matters. The population at large must be educated to understand the problems presented by alcoholism and drug addiction. The public must also come to a frank and

sensible attitude about the social evil. National prohibition has been an astounding revelation as to what can be done by even a relatively small amount of enlightened public opinion operating shrewdly. It would seem that much might be expected within a very few years by way of control of these two great causes of mental breakdown. Syphilis is evidently the outstanding problem at present. But at least there is discussion of the problem of venereal disease; the situation is coming to be understood. It is not too much to expect that medical research may contribute discoveries largely assisting in the control of the disease. So control of both syphilis and alcohol may be confidently expected. And with that control should come such a simplification of the total situation as will make clearer the exact importance of other factors.

As has already been pointed out, alcohol in particular is a confusing element in the study of the etiology of pathological mental conditions; in many cases it is simply impossible to tell whether a man drinks because he is feeble-minded or is "feeble-minded" because he drinks—whether or not an alcoholic spree brings on an attack of epilepsy or whether the period prodromal to the attack led to the alcoholic bout. Always one wonders, in studying an alcoholic manic-depressive case, whether the man drinks to drown his sorrows or facilitates an attack of his depression by failure to control his drinking—or whether perhaps the alcohol may not carry him through an attack of his difficulty with somewhat less mental distress than would be the case otherwise. National prohibition is the great experiment of fascinating interest in this connection.

Control of "Mental" Factors Contributing to Mental Ill-health

Now with regard to these other factors. It appears not impossible that this final analysis may show training and economic and social environment to be much more prominent, in bringing about mental difficulties, than has been realized. The writers have reiterated the notion that the emphasis on

eugenics of a few years ago was, essentially, an unfortunate effort to shift the responsibility for social failures from society to heredity. The more recent study of the causation of the neuroses suggests that such conditions may be due quite largely to certain rather restricted types of emotional maladjustment. Unfortunate home situation and training, unfortunate school situations, immeasurable blundering so far as sex education is concerned, seem to function subtly but powerfully in the causation of many borderland conditions and even in the development of unmistakable psychoses. Such difficulties appear to be, in their early stages at least, largely curable by means of a little sympathetic help and guidance. In fact, a few simple facts of emotional hygiene and emotional common sense sometimes completely modify the situation; and when one realizes how easily the whole difficulty might have been prevented, the situation appears pitiable in the extreme.

The Mental Hygiene of Childhood. The first and perhaps most important problem is evidently the problem of mental hygiene in childhood. These early formative periods are important because abnormal developments frequently begin with incidents or circumstances early in the life of the individual, and because where there is some inherited nervous weakness this manifests itself very early and so requires that from the very beginning of the child's life there be the proper hygiene and guidance.

The major requirements of a satisfactory mental hygiene for childhood are, after all, comparatively simple. There must first of all be, from early infancy, a consistent policy leading to the establishment of certain fundamental physiological habits and equally fundamental emotional attitudes. From babyhood the child should sleep, eat, and have his day governed by a carefully planned routine. Such a regimen will make for physical health and the avoidance of fatigue, and so conduce to a happy disposition. There must also be, in what times of emotional crises may arise, a firm handling of the situation. A child must not learn that it can have its way by

tantrums.[1] Such fundamental habits and attitudes are ordinarily established long before the child comes to school; the pre-school age is thus an exceedingly important time for mental hygiene. But good habits are important, of course, all through childhood—and are vital in carrying the adolescent or adult through any time of emotional stress.

There must also be, for a satisfactory mental hygiene program for the child, schooling which takes account of the child's capacities and interests. It is vital for the development of capacities that they be early recognized and given opportunity to function. It is vital also for development of both intellect and character that the child should neither habitually fail nor be habitually unoccupied.

The modern movement for adjustment of school work to intelligence will undoubtedly make its definite contribution to emotional health. All too often, under the old grade system, children developed inferiority complexes which were a handicap and source of unhappiness throughout life, as a result of repeated failure in school. It must be thoroughly understood that it is success and not failure which stimulates. The child must be given work he can do and in which he can take pride. It can, of course, be simple work. But it is essential to the learning process, and to the development of character, that there be successes.

A program for the mental hygiene of the child will include, in the third place, concerted plans for the avoidance of emotional conflicts. This will involve at once better sex education of the child (and more especially of parent and teacher regarding attitudes they should take toward the child's sex problems). The services of what has elsewhere been called an adjustment

[1] Real fear or illness must, of course, be distinguished from mere petulance. The writers knew of a baby that, because the mother required the constant care of a nurse for some time after its birth, slept in a dimly lighted room during the first weeks of its life. The child was simply terror stricken when an effort was then made to have it sleep in the dark. Only by a gradual use of dimmer and dimmer lights over the period of a year was this fear overcome. This child had paroxysms, not of temper, but of fear.

specialist are probably desirable to look after the mental health of the children of a school in somewhat the same fashion that school doctor and nurse look after physical health. Not all conflicts are of a sex nature, however; a great variety of factors (difficulty with playmates, physical defect—perhaps of an obscure nature—doubts about being really wanted in the home, antagonism toward some one member of the family) may operate to bring about conflict.

If a child suffering from an emotional conflict (or an adult either for that matter) can only talk out his difficulties to a sympathetic older person or adviser, this freeing of the mind often helps remarkably. But it is of vital importance that the person to whom the child unbosoms himself should not show disgust, irritation, or contempt for anything in the revelation. Such lack of understanding can have very serious consequences in intensifying the child's repression and anxiety.

Finally, the child must be adequately socialized. The shut-in personality must not be allowed to develop. The only child, or the favorite child, must not be permitted to develop and continue an infantile dependence upon his family. The naturally egotistical child and the self-assertive child must be adjusted so that they can get along with other children. It is probable that the schools of the future will pay at least as much attention to adequate socialization of the individual as to the present narrow, formal type of education to which most schools now confine themselves. Adequate socialization is exceedingly important for the maintenance of sanity and emotional health.[1]

[1] Valuable material on the mental hygiene of childhood will be found in the following references: Glueck, B., "Constructive Possibilities of a Mental Hygiene of Childhood," *Mental Hygiene*, Vol. 8, pp. 650-67, 1924; White, W. A., "Childhood, the Golden Period for Mental Hygiene," same journal, Vol. 4, pp. 257-67, 1920; Chadwick, Mary, "The Child's Position in the Family," *The Child*, Vol. 13, pp. 358-61, 1923; Richards, E. L., "The Elementary School and the Individual Child," *Mental Hygiene*, Vol. 5, pp. 707-23, 1921; O'Shea, M. V., and others, *The Child: His Nature and Needs*, The Children's Foundation, Valparaiso, Indiana, 1924, p. 516; Morgan, J. J. B., *The Psychology of the Unadjusted School Child*, Macmillan, 1924, p. 300.

Mental Hygiene of Adolescence. With adolescence other problems become acute. Further sex information must, of course, be given. But perhaps most serious is a new problem of heterosexual social relationships and associations. Such relationships and recreation are vital for emotional health during the adolescent period. Society owes it to the adolescent to make readily available to him these experiences for which his whole nature craves. But very often an adolescent finds himself or herself in a situation where it is almost impossible to attain these satisfactions. A crisis is almost sure to follow.

The adolescent going to a new place is almost certain to have some difficulties of this sort. The delinquent girl is very often the victim of such circumstances. The girl is attracted, we will say, from a home on a farm to the city. There is nothing particularly reprehensible about this: in fact the farmer boy coming to seek his fortune in the city has become something of a romantic figure, and has won his place in American traditions—and in American fiction. The country girl, however, has been granted no such favored status. If she does adventure to the city, she finds a situation with which she is not usually equipped to deal. Social attitudes and customs in the general population lag years behind the times, anyhow. And though such a girl may have a place in the economic situation which grants her something approaching economic equality of opportunity, the attitude toward her, outside of working hours, is still very largely the attitude of fifty or seventy-five years ago toward the unattached woman in a city. Her opportunities for recreation, and particularly her opportunities for social satisfaction, are very limited. It is not at all surprising that, frequently, she fails to keep out of trouble in this perverse and well-nigh impossible situation. This trouble may be delinquency. Or there may be episodes of a hysterical sort. Even though nothing definite happens, the girl nevertheless suffers acutely from her social and recreational starvation.

Satisfactory vocational guidance for the adolescent will avoid many difficulties which might lead to neuroses or other

unfortunate conditions. . . . In short, the problems of a mental hygiene of adolescence are legion, but have been sufficiently implied in previous pages and need not be further elaborated at this time.[1]

Mental Hygiene in Adult Life. In adult life still other problems appear. The complex problems of marriage, the strain of earning one's own living and maintaining one's self in society, the problems of industrial relationship, the comparatively little recognized difficulties of the housewife—again there are a thousand topics, too complex to be more than mentioned here, but each one involving factors affecting mental health.[2] Space remains only for brief mention of these matters as they bear upon personal mental hygiene.

Something should first be said regarding factors contributing to the mental hygiene of the adult, however. The average social agency, of course, does much such work. So, often, does the church. The school which functions as a community social center does much.

It has been already mentioned that the feeble-minded can be supervised in the community so that they do not become a problem. Perhaps an extension of friendly supervision over a larger group would be worth while. After all, everyone is supervised to some extent, in one way or another, at least by the police.

It has also been pointed out that neurotic individuals

[1] For discussion of the problems of adolescence see, for example, Taft, Jessie, "Mental Hygiene Problems of Normal Adolescence," *Mental Hygiene*, Vol. 5, pp. 741-51, 1921; Williams, F., "Mental Hygiene of the College Student," *Mental Hygiene*, Vol. 5, pp. 283-301, 1921; Pringle, R. W., *Adolescence and High School Problems*, D. C. Heath & Co., 1922, p. 386; Van Waters, Miriam, *Youth in Conflict*, Republic Publishing Company, 1925, p. 293.

[2] For the reader interested in these subjects the following references will prove of value: Pratt, G. K., "The Problems of the Mental Misfit in Industry," *Mental Hygiene*, Vol. 6, pp. 526-38, 1922; Southard, E. E., "A Movement for a Mental Hygiene of Industry," same journal, Vol. 4, pp. 43-64, 1920; Jarrett, M. C., "Mental Hygiene of Industry," same journal, Vol. 4, pp. 867-84; White, W. A., *Principles of Mental Hygiene*, Macmillan, 1917, p. 323; Malchow, C. W., *The Sexual Life*, C. V. Mosley Co., 1921, p. 306; Myerson, A., *The Nervous Housewife*, Little, Brown and Co., 1920, p. 261.

needed the help of an "adjustment specialist" (psychiatrist or clinical psychologist) to guide them out of their difficulties. Most people need such help at some time in their lives, however. In the not distant future, it may be that the adjustment specialist will be as well recognized, and at least as important, as the specialist in various forms of physical disease.

Maintaining One's Own Mental Health

The question here is: What can one do to maintain one's own sanity and emotional health and efficiency? The writers suggest that an individual somewhat anxious regarding these matters should consider the following suggestions:

(1) Such an individual should first have a thorough physical examination. Such an examination may contribute in a number of ways to the situation. It may locate some physical factor (as a focal infection, digestive difficulty, glandular dysfunction), treatment of which may result in marked improvement of the general tone and efficiency and change the whole mental outlook. It may show a generally run-down condition physically—a condition secondary, perhaps, to the mental crisis, but needing attention in its own right. The examination may be negative; the individual may be in good physical condition. This is reassuring. It will help eliminate or prevent hypochondria.

(2) The individual should inform himself regarding matters of mental health and hygiene. Such information will give him better self-understanding—and is (the writers are convinced) at least as important for wise governing of one's life as information regarding the elements of physiology and physical hygiene. With such reading will come a better sense for the proportion of one's own difficulties (together with a very valuable understanding of and tolerance for the difficulties of those with whom one comes in contact). With such understanding will follow also a lessening of the fear that comes with failure to understand the nature of any disease, and elimination of the old superstitions regarding such mat-

ters and correction of the older crass misinformations. Mere information is itself frequently all that is necessary to prevent an intelligent individual from getting into nervous and mental difficulties.

For such information a general treatment of the whole field should be first gone over in order to get perspective. It has been one purpose of this book to give such an overview of the whole subject to serve this end. There should also be no little reading of actual case studies, because no general treatment alone is adequate to the presentation of topics in which the individuality of the patient so largely enters, and because only by reading reports of actual cases can one come to a sense of the concrete reality of these facts. Such reading may be at times slightly more frank than the modern novel; but it is more interesting reading, and much more informing and profitable.

(3) With such reading as a background one should make a study of one's own case and one should attempt to deal intelligently with what problems one may have. The most likely situation, if there is occasion for hygiene, is that the individual is in a situation which has the makings of an emotional conflict. There should then be a calm facing of the facts and an effort at solution or avoidance of the difficulty. Thus if a young married woman lives near her parents, and the mother constantly interferes with the daughter's housekeeping and home life, the daughter will naturally first try to make the older woman come to an appreciation of the situation. If this effort is not successful, it may be best for the daughter to move to a distant part of the city—or even to another locality. Otherwise, the home life, happiness, and emotional health of the daughter may be jeopardized.

This does not mean, of course, that every passing adolescent ebullition should be handled with ponderous seriousness, or that after every domestic quarrel some one should leave home. But persistent problems of adjustment should not be neglected.

(4) One should have work, work which is reasonably satis-

fying and which keeps one occupied for a reasonable working day. It should not be work that is beyond one's capacities. If the work is, for some reason, persistently incompatible, one should have the courage to obtain a position which is not thus distressing.

Again, this does not mean that a man should leave his job with every passing difficulty. But it is equally unwise to remain indefinitely in an uncongenial position which is a constant source of emotional irritation. One should get as congenial work as possible. And then one should make a persistent effort to develop a maximum of interest in and enjoyment of such work.

(5) Finally, every one needs friends and adequate social contacts. The "good mixer" of course requires no encouragement along these lines. But many people are more or less awkward in their attempts at friendships. If an individual is troubled with difficulties of this nature, he should realize that there are plenty of others who are equally awkward—and equally as anxious to be friends. It is necessary to go where friendships may be made—to social events, to classes, lectures, to parties, clubs, vacation places—and after arriving it is necessary to make an effort at being friendly. It is astounding how two homesick college students will sit next to each other in a class for an entire semester without making any attempt at acquaintance. Friends are of the greatest value in preserving a sane attitude toward life; they contribute greatly to one's happiness, and are of inestimable value in times of emotional crisis. The isolated individual is always good soil for the growth of mental troubles.

It should be pointed out that most types of recreation are particularly valuable in bringing the individual in contact with others—aside from the physical advantages in rest and change, and temporary escape from the cares of everyday life. The lonely person will do well to try out for a ball team, volunteer as a helper in running a playground, or similarly exert himself, so as to come into informal contact with others.

It is, of course, obvious that the above suggestions are not the only ones that might be made or that would be of value. They are presented because they seem particularly likely to be of help to people who are in need of mental hygiene. If these five suggestions are carried out, it is likely that the individual will find that other troubles, which did not seem to be susceptible of solution by any of the methods mentioned above, have somehow disappeared. It an individual can get himself into good physical condition, if he can inform himself concerning the principles of mental health, if he can get rid of —or adjust to—any emotional conflicts that are troubling him, if he can find work that is congenial—or better still, actually interesting—and if he can build up social contacts that are satisfying, he will find himself highly resistant to the most common types of mental difficulty.

Cause and Prevention of Mental Difficulty by Society

In the chapter on causation it has already been mentioned that society is largely responsible for the presence of abnormal mental conditions. It is responsible for the prevalence of syphilis and alcoholism, and the excessive fecundity of the defective. The great majority of functional conditions are but evidence of the inadequacies of the present social organization—are products of society's failure to provide even a modicum of training for parenthood, to school children with any reasonable recognition of their natures or their needs, to provide for those recreational and social experiences which are almost as vital for the child and adolescent as breathing, to assure to the adult work, and a reasonable comfort. It remains to be emphasized that a comprehensive program of mental hygiene may be expected to accomplish very remarkable things.

It is obvious that a campaign leading to the control of syphilis, or alcoholism, or the drug evil will accomplish much. But it must be emphasized that the situation is much more complex, that it has innumerable contacts with everyday

living. Problems of mental health cannot be separated from problems of industrial hygiene, the living wage, industrial unrest, unemployment, problems of recreation, problems of religion and morals, problems of racial antagonism, problems of marriage and divorce and the whole subject of the relations between the sexes and the place of woman in modern society. Efforts at the solution of any of these problems are efforts for mental hygiene.

The situation might seem so tremendously complex as to be discouraging. The writers are convinced that, on the contrary, the opposite attitude is warranted. The work being done upon all the various phases of mental hygiene is cumulative in its effects. Progress is becoming constantly more rapid. There is one element in particular, in the situation, which has the greatest promise. This is the marked and increasing popular interest in, and understanding of, these problems of mental health.

The awakening shows itself sometimes in amusing fashion in the somewhat vague and somewhat morbid interest of college students in classes in abnormal psychology. Magazine readers seem always to like plots involving episodes of a mentally pathological nature (and it is curious to note that the reading public has become wearied of crude, hypnotic episodes and expects more subtle affairs, perhaps verging on the Freudian). All too popular lecturers on "psychology" make astounding sums, and mushroom magazines exploiting this quack psychology (usually a queer mixture of Freudianism, "animal magnetism," Couéism, mysticism, sentimentality, and platitudes) are on every news stand. Books ranging all the way from such "stuff" to elaborate technical studies are constantly appearing in this field. Even thoroughly reputable magazines are loaded with advertisements of methods of developing will-power, personality, or advice to prospective mothers or prospective husbands or prospective fiancées. . . . Not that all of this is admirable, but it at least shows interest. Almost wholly admirable are the carefully organized efforts of the psychiatrists to educate the public to a better understanding of the problems of mental disease and to enlist the aid of the public in constructive efforts to deal with the

problem. The mental surveys of recent years, in some states, aiming to determine the number of feeble-minded, epileptic, and insane in the commonwealth, are only one feature of the movement. The formation of mental hygiene societies in the various states is part of the "propaganda." The National Committee for Mental Hygiene operates to give a coherence to all these activities which is often lacking in such movements.

Such a development of general understanding of this total subject is evidently prerequisite to further organized efforts at dealing with these problems. But there is in the situation a unique feature, which seems usually not noticed. It appeared that eugenic control could come only *after* a long process of general education with regard to these problems. It also appeared that much the same situation existed as far as syphilis was concerned; a long process of education of the public was necessary, *and only after that* could systematic control be developed. *Control of the psychogenetic factors may be supposed by no means so difficult.* The process of general education, *in itself,* will remove major causes of mental breakdown and ill-health. With a saner attitude toward sex matters, and with a better general understanding of child life, of personal mental hygiene, of problems of adjustment in school, home, and work, we may surely hope that the general mental health will greatly improve. The situation is extremely interesting. In the control of physical disease the education of the public can serve only as a means toward that control. Here the process of education will function as an actual part, in fact, the essential part, of the control and prevention. The situation with regard to mental ill-health may surely be expected to improve very rapidly, within the next few years.

And it need hardly be added that these developments will mean not merely a smaller number of individuals in institutions, or invalided by neurosis. They will mean an increase in the general level of intellectual efficiency, emotional (and physical) health, and happiness, and will affect the daily living of everyone.

The development of the Mental Hygiene movement is, then, the most interesting and important of all activities coming from study of mental disease and deficiency. This last chapter has tried to point out the following facts regarding this movement: (1) The attitude toward mental disease and defect has changed markedly (even astoundingly) during the past few years. (2) Attempts at control of feeble-mindedness are now stressing, not eugenics, but adaptive training of the subnormal and supervision in the community. (3) Progress is being made toward control of such causes of mental disease and deficiency as alcohol, drugs, and syphilis. (4) Progress is being made toward such early habit-forming, individualization of school training, socialization, guidance in school and vocation, and adjustment in emotional difficulty, as will prevent functional nervous and mental disturbances. (5) Sufficient is now known about these matters, so that an intelligent individual can do much toward the maintenance of his own efficiency and emotional health; brief suggestions are given toward such personal mental hygiene. (6) It is stressed in closing, that the great causes of mental ill-health are in a peculiar way and to a remarkable degree readily controllable by society. And it is emphasized that progress in these matters is becoming constantly more rapid, and will ultimately contribute, in so small measure, to the general well-being.

References—Part III

A large proportion of the references dealing with the subjects discussed in Part III are articles in the journals, and have to do with very specific topics. For the most part these articles have been referred to in notes following the discussion of these topics in the text. The following list does not repeat these references, but adds certain others, in most instances of a somewhat more general nature.

1. Causes.

Tredgold, A. F., *Mental Deficiency,* Chap. 3.

Breckenridge, S. P., and Abbott, E. H., *The Delinquent Child and the Home,* Chaps. 3-10.

White, W. A., *Outlines of Psychiatry,* Chap. 4.
Goldberg, J. A., *Social Aspects of the Treatment of the Insane,* Chap. 2.
Burt, C., *The Young Delinquent,* Chaps. 2-12.
May, J. V., *Mental Disease: a Public Health Problem,* Part I, Chaps. 8, 9, 12.
Bailey, H., *Nursing Mental Diseases,* Chap. 4.
White, W. A., and Jeliffe, E. R., *Modern Treatment of Nervous and Mental Diseases,* Vol. I, Chaps. 1, 3, 6, 7, 10.
Emerson, L. E., *Nervousness,* Chaps. 1, 2.
Sidis, B., *Causes and Treatment of Psychopathic Diseases,* Chaps. 3-6.
Glueck, B., "The Concept 'Nervous Child,'" *American Journal of Psychiatry,* Vol. 3, pp. 515-526.
Taylor, M., "The Child and the Home," *Mental Hygiene,* Vol. VI, 746-772, Oct., 1922.
Goddard, H. H., *The Kallikak Family.*
Dugdale, R. L., *The Jukes.*
Kempf, E. J., *Psychopathology,* especially Chaps. 1-4.
Burnham, W. H., "Success and Failure as Conditions of Mental Health," *Mental Hygiene,* Vol. 3, pp. 387-397, 1919.
Van Waters, M., *Youth in Conflict,* Part I.
Rosanoff, A. J., *Manual of Psychiatry,* Chap. 1.
Sands, I. J., and Blanchard, P., *Abnormal Behavior.*
Goddard, H. H., *Feeblemindedness: Its Causes and Consequences,* Chap. 4.

2. Treatment.

Tredgold, A. F., *Mental Deficiency,* Chap. 19.
Pfister, P. R., *Psychoanalysis in Education.*
Jeliffe, S. E., *Technique of Psychoanalysis.*
Kempf, E. J., *Psychopathology,* especially Chap. 15.
Burt, C., *The Young Delinquent,* Chaps. 2-12.
Burleigh, E. V., *The Delinquent Girl.*
Stekel, W., *Psychoanalysis and Suggestion Therapy.*
White, W. A., *Outlines of Psychiatry,* Chap. 5.
Rosanoff, A. J., *Manual of Psychiatry,* Chaps. 8-10.
Goldberg, J. A., *Social Aspects of the Treatment of the Insane,* Chaps. 3, 5.
May, J. V., *Mental Disease: a Public Health Problem,* Part I, Chaps. 4, 5, 6.
Bailey, H., *Nursing Mental Disease,* Chaps. 7-12.

White, W. A., and Jelliffe, E. R., *Modern Treatment of Nervous and Mental Diseases,* Vol. I, Chaps. 2, 4, 8, 12, 13, 14; Vol. II, entire.
Emerson, L. E., *Nervousness,* Chap. 6.
Sidis, B., *Causes and Treatment of Psychopathic Diseases,* Chaps. 17-20.
Perkins, N. L., "Mental and Moral Problems of the Woman Probationer," *Mental Hygiene,* Vol. VIII, pp. 506-521.
Dubois, P., *Psychic Treatment of Nervous Disorders,* Chaps. 17-19, 30-33.
Coriat, I., *What Is Psychoanalysis?*
Graham, Mulhall S., "After-Care of the Narcotic-Drug Addict," *Mental Hygiene,* Vol. IV, 605-610, July, 1920.
Bingham, A. T., "What Can Be Done for the Maladjusted?" *Mental Hygiene,* Vol. IV, 422-433, April, 1920.
Green, G. H., *Psychoanalysis in the Classroom.*
Burt, C., *The Young Delinquent.*
Maxfield, F. N., "Salvage of the Feeble-minded," *American Review,* Vol. II, pp. 308-317, 1924.
Ellis, M. B., *The Visiting Teacher in Rochester.*

3. Mental Hygiene.

Goldberg, J. A., *Social Aspects of the Treatment of the Insane,* Chap. 6.
Bailey, H., *Nursing Mental Disease,* Chap. 5.
White, W. A., *Mental Hygiene of Childhood.*
Martin, L. J., *Mental Hygiene,* Chaps. 5-9.
Paton, S., *Signs of Sanity.*
Eyre, M. B., *Psychology and Mental Hygiene for Nurses.*
Southard, E. E., "A Modern Specialist in Unrest: A Place for the Psychiatrist in Industry," *Mental Hygiene,* Vol. IV, pp. 550-563, July, 1920.
Haines, T. H., "Mental Hygiene Requirements of a Community," *Mental Hygiene,* Vol. IV, pp. 920-931, 1920.
Abbott, E. S., "A Program of Mental Hygiene in the Public Schools," *Mental Hygiene,* Vol. IV, pp. 320-330.
Campbell, J. M., "Mental Hygiene in Industry," *Mental Hygiene,* Vol. V, pp. 468-478, July, 1921.
Williams, F. E., "Community Responsibility in Mental Hygiene," *Mental Hygiene,* Vol. VII, pp. 496-508, 1923.
Burnham, W. H., *The Normal Mind.*
Campbell, C. M., "Coeducation of Children and Parents," *The Family,* Vol. I, pp. 1-3, January, 1921.

Gilston, C. F., "Mental Hygiene in Health Centers," *Mother and Child,* Vol. III, pp. 75-79, 1922.

Howard, M. Q., "Mental Hygiene in the Public Schools," *Nation's Health,* Vol. V, pp. 15-16, 1923.

Taft, Jessie, "Relation of the School to the Mental Health of the Average Child," *Mental Hygiene,* pp. 673-687, 1923.

Thom, D. A., *Mental Hygiene Leaflets for Parents,* National Committee for Mental Hygiene, 1924.

Williams, F. E., "Community Responsibility in Mental Hygiene," *American Review,* Vol. I, pp. 56-64, 1925.

Elkind, H. B., "Industrial Psychiatry," *Journal of Industrial Hygiene,* Vol. 6, pp. 251-58, Oct., 1924.

Exercises in Application

1. Write out case studies, including differential diagnosis, for (a) some delinquent you have known, (b) some ne'er-do-well, (c) some very poor student in school, and (d) some adolescent you have known who showed peculiarities at adolescence.
2. Look up the report from your own state of the number of insane, feeble-minded and epileptic individuals being cared for by the state. How much money does your state have invested in hospitals for the mentally diseased and institutions for the epileptic and feeble-minded? Compare the grounds and buildings at the "feeb" school with the equipment of the public school you first attended.
3. If possible visit the local jail and attend a session of a local court. Were there any cases which seemed to you to involve mental peculiarity?
4. Make a list of all cases, not in institutions but whom you judge should have had institutional care, whom you have known. Include both the feeble-minded, psychotic, and the persistently criminalistic. Give reasons for each inclusion.
5. When and how did you first learn about venereal diseases? What do you think should be the policy of the schools as to the giving of such information?
6. Describe any family you have known in which there seemed to be some hereditary peculiarity or weakness. What about the home life in this family?
7. Write up a case history of some person you have known whose difficulties were largely due to environmental influences. How might the environment have been altered to remove these influences? Make a list of any environmental influences that

might cause a child to develop wrong habits of behavior, such as stealing, lying, running away from home, etc. Which of the factors you have listed could be removed if the general public really wanted to get rid of them?

8. Do you know any children who have "tantrums"? Any solitary, "shut-in" children, any spoiled children? Any adults who as children were of one of these types?
9. Did you ever think you were "going crazy"? Give the circumstances. What is your diagnosis now? What "complexes" have you? Consider the suggestions in the last chapter regarding the maintenance of one's own mental health. Are there any suggestions which seem to apply to you? How has your reading of this book changed your attitude toward yourself?
10. List things which might be done in your community for better Mental Hygiene. What might be your contributions in any such endeavors? Have you known any communities in which there has been such work?

APPENDIX

APPENDIX A

CASE-STUDY OUTLINE

The case-study outline discussed in Part I is brought together below for convenience in case-study work. It will be noted that in addition to the topics previously presented certain accessory items of information are also mentioned. On the line marked "Referred by:" should be given the name of the person (associated charities worker, juvenile court judge, teacher, employer) by whom the case was referred to those making the study—and to whom a report should, presumably, be made. At the end, under "Follow-up notes" is a space for later jottings about the case on the assumption that the investigator (or some one acting in his place) keeps in contact with the individual and learns from time to time how he is getting on. There should always be such continuing contacts. . . . It is fascinating to know "what happens next" and "how it all came out."

Name ..... *Age* ..... *Sex* ..... *Race* .....
Birthplace .....
Marital Status ..... *Home Address* .....
Occupation ..... *Business Address* .....
Referred by .....
Name and address of nearest relative .....
.....
Names and addresses of other persons who are sources of information regarding the case (give relation to or connection with the case, in each instance) .....
.....
.....

I. History of the Family.
   A. Medical History.
   B. Social History.
   C. Educational History.
   D. Economic History.

II. History of the Individual.
  A. Medical History.
    Childhood.
    Adolescence.
    Adult Life.
  B. Social History.
    Childhood.
    Adolescence.
    Adult Life.
  C. Educational History.
  D. Economic History.

III. History of the Present Crisis.
  A. Medical History
      Symptoms and Course.
  B. Social History.
      Symptoms and Course.
  C. Educational History.
      Symptoms and Course.
  D. Economic History.
      Symptoms and Course.

IV. Present Condition.
  A. Physical Condition.
    General Health.
    Special Defects.
  B. Appearance and Behavior.
  C. Intellectual Condition.
    General Level.
    Special Functional Disorders: as in judgment, attention, memory, association, perception.
  D. Emotional Condition.
    General Emotional Tone.
    Special Emotional Trends.
    Emotional Conflicts.

V. Summary and Conclusions.
  A. Summary.
  B. Conclusions.

Follow-up Notes.

APPENDIX B

JOURNALS DEALING, WHOLLY OR IN PART, WITH PROBLEMS OF MENTAL ABNORMALITY AND DEFICIENCY

In any subjects developing as rapidly as those dealt with in this volume, the only way to keep in touch with progress is by reading the journals dealing with these topics. Certain of the best of such journals are listed below, with brief comments. It is very strongly urged that these journals be looked over. It is believed that continuing contact with them will prove very valuable.

American Journal of Psychiatry. Quarterly. $5.00. Johns Hopkins Press, Baltimore, Md. Edited by E. N. Brush. Official organ of the American Psychiatric Association. Contains very valuable studies of the psychoses, and also of borderland conditions and abnormal conditions in childhood.

American Review. Bi-monthly. $3.00. V. T. Thayer, editor; G. A. Brown, publisher, Bloomington, Illinois. An excellent general review the editors of which are distinctly interested in problems of mental hygiene, and which usually carries at least one article bearing on such topics. The book reviews are also very good and are frequently of books having a bearing on this field.

Eugenics Review. Quarterly. 10s. Macmillan and Co., London. An English journal of eugenics which includes material on inheritance of mental defect and related topics.

Hygeia. Monthly. $3.00. Published by the American Medical Association, 535 N. Dearborn Street, Chicago. A very valuable magazine, bringing much reliable medical information to the general public. Deals with the whole field of medicine. Includes good brief articles on child hygiene, nervous difficulties, and so on. Carries contributed articles, book reviews, and a valuable section dealing with answers to ques-

tions. Very much worth while from many points of view, because of the trustworthiness of the matter it carries.

Industrial Management. Monthly. $3.00. Published by the Engineering Magazine Co., 120 West 32nd Street, New York. J. R. Dunlap, editor. A journal carrying some articles on employment management bearing somewhat on problems of mental health.

Journal of Abnormal and Social Psychology. Quarterly. $5.00. Boyd Printing and Publishing Co., 372-4 Broadway, Albany, N. Y. Morton Prince and H. T. Moore, editors. Articles dealing with abnormal manifestations, such as hypnosis, neurotic conditions, dreams, treatment of mental disorders, and various problems of social psychology. Includes book reviews, editorials, and correspondence.

Journal of Applied Psychology. Quarterly. $5.00. James P. Porter, Ohio University, Athens, Ohio, editor. This journal carries articles on the application of psychological principles primarily to business, but also to various other fields of activity; among them are to be found articles applying psychology to the work of clinics, courts, and schools.

Journal of Applied Sociology. Bi-monthly. $2.50. Published by the Southern Californian Sociological Society and University of Southern California, 3351 University Avenue, Los Angeles, Cal. E. S. Bogardus, editor. Includes articles dealing with problems of emotional and social adjustment, as well as discussions of sociological matters bearing on problems of mental health. Includes book and periodical notes.

Journal of Criminal Law and Criminology. Quarterly. $3.50. Northwestern University Press, 31 West Lake Street, Chicago, Ill. R. H. Gault, editor. Includes studies of reformatory and other criminal groups with reference to mental status, and other articles touching upon mental abnormality.

Journal of Delinquency. Bi-monthly. $5.00. Whittier State School, Whittier, Cal. Editor, E. B. Sullivan. Carries excellent material dealing with the study of delinquents.

Journal of Industrial Hygiene. Monthly. $6.00. Published by the Harvard Medical School, 55 Van Dyke Street, Boston. Carries some articles on mental hygiene in industry, although the majority of the articles are concerned with factors affecting the physical condition of the workers.

Journal of Nervous and Mental Diseases. Monthly. $10.00. S. E. Jeliffe, editor, 64 W. 65th Street, New York. A very valuable technical journal carrying contributed articles, and also extensive reviews of current books and periodical literature in this field.

Journal of Personnel Research. Monthly. $5.00. W. V. Bingham, editor. Williams and Wilkins Co., Baltimore, Md. A journal dealing with personnel management and carrying some material of interest in the mental hygiene field. Includes contributed articles and reviews.

Journal of Psycho-Æsthenics. Lew A. Cummings Co., Manchester, N. H. Editor, B. W. Baker. The journal at present consists of papers given by the members at the annual meetings of the American Association for the Study of Feebleminded. All papers deal with the care and training of feebleminded individuals.

Journal of Social Hygiene. Monthly (9 issues). $3.00. Published by the American Social Hygiene Association, 372-4 Broadway, Albany, N. Y. R. H. Everett, editor. A journal devoted to problems related to sex. Contains valuable articles on venereal disease, problems of sex education, social problems related to sex.

Mental Hygiene. Quarterly. $3.00. Published by the National Committee for Mental Hygiene, 370 Seventh Avenue, New York City. Frankwood E. Williams, editor. Probably the most valuable single journal in this total field, for the layman, but includes much material which the expert in these fields will find of first importance. Carries contributed articles of a high standard (and almost always very well written) on a wide range of topics, book reviews, summaries of important monographs, and relevant articles appearing in other journals. The reviews are also of a high average standard.

Pedagogical Seminary and Journal of Genetic Psychology. Quarterly. $5.00. Published by Clark University. Carl Murchison, editor. Carries articles on child study, including abnormalities in children, studies of racial groups, criminal groups, etc., and book reviews.

Psychoanalytical Review. Quarterly. $6.00. Nervous and Mental Disease Publishing Company, Albany, N. Y. Editors, White, W. A., and Jeliffe, S. E. This journal contains original

papers dealing with the use and value of psychoanalysis in meeting the problems of mental disease. Presents the latest developments in this field. Contains book reviews.

Psychological Clinic. 9 numbers per year. $3.00. The Psychological Clinic Press, Woodland Avenue and 36th Street, Philadelphia, Pa. Lightner Witmer, editor. Has to do especially with the study of individual children, and the diagnosis of abilities.

School and Society. Weekly. $5.00. The Science Press, Lancaster, Pa. J. McKeen Cattell, editor. Carries a variety of material on educational topics including some articles on matters of mental hygiene, adjustment of school to ability, etc.

The Child. Monthly. $5.25. J. Bale Sons and Danielson, London. T. N. Kelynaak, editor. An English journal dealing with child welfare.

The Survey. Fortnightly. $5.00. Published by Survey Associates, 112 East 19th Street, New York. Paul M. Kellogg, editor. Brief, but vigorous articles, comments, and reviews, on social problems, including problems of mental hygiene.

Ungraded. Ungraded Teachers' Association of New York City, 17 Lexington Avenue, New York. Monthly. $0.50. Editor, Elizabeth E. Farrell. This magazine carries articles on materials and methods for uses in ungraded classes. It has also numerous articles on nervous children.

BIBLIOGRAPHY

As has already been mentioned, there has been in recent years a simply extraordinary output of books having to do with mental abnormality. These have been of all degrees of merit—chiefly, one is tempted to add, they have been bad[1] or indifferent. But so many have been at least fairly good that it is difficult to make any selection. The volumes listed below are believed to be reasonably representative of the better productions in this total field, however. Each book has been roughly characterized, in a sentence or two, in an attempt at first guidance of the reader. Those discussions including case studies are felt to be especially worth while, as most likely to give the reader a sense for the reality of these problems.

It must be emphasized again here, however, that the reader who desires to continue and extend his understanding of these subjects must not neglect the journals. These periodicals will keep him up to date, will give him detail on matters only meagerly treated in most of the books—will call his attention to any good new books which may appear from time to time touching upon these fascinating problems.

Allbutt, T. C., and Fletcher, W. F., *War Neuroses.* Cambridge University Press, 1918, pp. 132.

The types of condition described are largely typical of all neuroses and happen to be described rather well. The general conclusions and inferences are by no means limited to wartime difficulties.

Anderson, N., *The Hobo.* The University of Chicago Press, 1923, pp. 302.

An excellent discussion of the sociology and psychology of homeless men.

Bailey, H., *Nursing Mental Disease.* Macmillan, 1921, pp. 175.

A brief discussion of the care of abnormal individuals from the nurses' point of view.

[1] The bad have been chiefly of two classes—exploitations of current interest in the abnormal, and monstrosities of "pan-sexuality." After all, there is something in human nature besides sex.

Baldwin, B. T., and Stecher, L. I., *The Psychology of the Pre-School Child.* D. Appleton & Co., 1924, pp. 301.
The major part of the book discusses the development of normal children in physical growth, motor control, perception, mental activity, social responses, etc.

Barr, M. W., and Maloney, E. F., *Types of Mental Defectives.* Blakiston's Son & Co., 1920, pp. 175.
This reference shows pictures of different types of feeble-minded individuals and gives brief descriptions of both the individual cases and the general types.

Bloomfield, M., *Youth, School and Vocation.* Houghton Mifflin Co., 1911, pp. 273.
A good discussion of the problem of educating young people for some vocation; a good reference to read as an introduction to vocational guidance.

Bogardus, E. S., *Methods of Training Social Workers.* S. Cal. Sociological Society, Los Angeles, 1921, pp. 27.
A short monograph covering the main points of case-study procedure, interviewing, diagnosis, record-keeping, and treatment. Good, but very brief.

Breckenridge, S. P., and Abbott, E. A., *The Delinquent Child and the Home.* Survey Associates Inc., 1916, pp. 349.
The authors place the major blame for maladjustment among children on the environment, considering such factors as recent immigration, poverty, crowded home conditions, ignorance, etc., as the main cause of difficulty, rather than the nature of the child.

Burleigh, E. N., and Harris, F. R., *The Delinquent Girl.* New York School of Social Work, 1923, pp. 118.
This reference gives a very good presentation of parole work and other methods of after-care and supervision of delinquent individuals.

Burnham, W. H., *The Normal Mind.* D. Appleton & Co., 1923, pp. 702.
An excellent presentation of the methods by which normal reactions develop. The reference deals with such matters as the conditioned reflex, inhibitions, habits, etc., and their relation to the task of school and community in the work of mental hygiene.

Burt, C., *The Young Delinquent.* D. Appleton and Co., 1925, pp. 607.
An excellent treatment of causation and treatment of delinquency, with many illustrative case studies. The most recent and one of the very best books on the subject.

CHAPIN, F. S., *Field Work and Social Research.* Century Co., 1920, pp. 212.
This reference contains one very pertinent chapter. The remainder of the book would be of great value to the social worker, but does not have a place in the present treatment.

Child Guidance Clinic, *Three Problem Children.* Joint Committee on Methods of Preventing Delinquency, 1923, pp. 146.
A very complete report of three children, showing sociological background, test results, physical examination, etc., together with the steps taken toward readjustment, and the "follow-up" supervision carried on until the children were no longer problems.

Commission on Mental Defectives in Indiana, *Mental Defectives in Indiana,* 1918, pp. 56.
A report of a state survey to determine the number of feeble-minded, insane, and epileptic needing institutional care.

CORIAT, I. H., *What Is Psychoanalysis?* Moffat, Yard & Co., 1919, pp. 126.
A very brief and clear discussion of the nature of psychoanalysis. The author presents his material in the form of questions frequently asked, and the answers.

CROTHERS, T. D., *Inebriety.* Harvey Publishing Company, 1911, pp. 365.
A somewhat old, but still good, discussion of the difficulties due to alcohol; the same author has a similar book on the users of narcotics.

DAVIES, S. P., *Social Control of the Feeble-minded.* The National Committee for Mental Hygiene, 1923, pp. 223.
In many respects the best single statement of the best thinking regarding the problem of the feeble-minded.

DEJERINE, J. J., and GAUTER, E., *The Psychoneuroses and Their Treatment by Psychotherapy* (trans. by Jelliffe), second English edition, Philadelphia, J. B. Lippincott Co., 1915.
Perhaps the best single reference on the subject. Neurasthenia, hysteria, and psychasthenia are discussed in some detail, and with excellent good sense.

DEVINE, E. T., *The Normal Life.* Douglas C. McMurtie, 1917, pp. 196.
A brief but good presentation of the major facts of the average "normal" individual's life. It lacks statistical data, but it is very suggestive of the characteristics of the healthy existence to which the average individual should be brought.

DIEFENDORFF, A. R., *Clinical Psychiatry.* Macmillan, 1921, pp. 562. (3rd American edition.)
A good psychiatry which is rather more readable and less loaded with medical terminology than many others of the same type.

Doll, E. A., *Clinical Studies in Feeble-mindedness.* R. G. Badger, 1917, pp. 232.
This reference is of value chiefly for its case studies of defective children.

Drucker, S., and Hexter, M. B., *Children Astray.* Harvard University Press, 1923, pp. 421.
Twenty-four very detailed and interesting case studies written from a sociological standpoint, with a brief introduction giving the methods used in case study. An excellent reference.

Dubois, P., *Psychic Treatment of Nervous Disorders.* Funk and Wagnalls, 1909, pp. 462. (6th ed. rev.)
One of the classic references in the field of psychotherapy. Good descriptions of symptoms are given, and equally good suggestions as to treatment. The style of the author makes this book especially easy reading for the beginner.

Dugdale, R. L., *The Jukes.* G. P. Putnam's Sons, 1910, pp. 102.
A study of a defective family through several generations.

Ellis, M. B., *The Visiting Teacher in Rochester.* Joint Committee on Methods of Preventing Delinquency, 1925, pp. 205.
A good reference on a rather new mode of attack upon the problem of adjusting school and child.

Emerson, L. E., *Nervousness.* Little, Brown & Co., 1916, pp. 184.
A short and rather popular discussion of the cause, nature and treatment of the more common types of "borderland" conditions.

Eyre, M. B., *Psychology and Mental Hygiene for Nurses.* Macmillan, 1922, pp. 208.
The reference points out the principles of mental hygiene as the nurse needs to know them in caring for her patients.

Franz, S. I., *Nervous and Mental Reëducation.* Macmillan, 1923, pp. 225.
A good presentation of methods of rehabilitation, but with emphasis upon nervous reëducation (as in walking, speech), rather than upon the changing of mental attitudes.

Freud, S., *Three Contributions to the Theory of Sex.* Nervous and Mental Disease Publishing Co., Monograph No. 7, 1920, pp. 112.
A rather technical, but good discussion of the importance of childhood experiences in determining the later sex life of the individual.

——— *Selected Papers on Hysteria and the Other Psychoneuroses.* Nervous and Mental Disease Publishing Co., Monograph No. 4, 1912, pp. 200.
This is one of the best known references in this field. The sex element in the cases presented, the importance of the "sub-

conscious," etc., are perhaps overemphasized, but the reference is very good as an example of work along these lines.

FRINK, H. W., *Morbid Fears and Compulsions.* Moffat, Yard & Co., 1921, pp. 344.
The reference is rather extreme in its viewpoint at times, but contains good material for the discriminating reader.

GODDARD, H. H., *Feeble-mindedness: Its Causes and Consequences.* Macmillan, 1914, pp. 599.
This reference contains a large number of case studies of feeble-minded children, together with discussion of the causes of feeble-mindedness and the relation of this condition to crime, prostitution, etc.

——— *The Kallikak Family.* Macmillan, 1914, pp. 121.
A classic investigation into the hereditary factor in the causation of feeble-mindedness. The report deals with two lines of descendants from a Revolutionary soldier, one going back to a child by a feeble-minded girl, the other the legitimate line from the normal wife.

GOLDBERG, J. A., *Social Aspects of the Treatment of the Insane.* Columbia University, 1921, pp. 247.
This reference gives a brief historical sketch of the attitude of society toward the insane, goes into the social nature of some of the causes of insanity, and presents an excellent discussion of the relations between the insane person and society.

GROSZMANN, M. P. E., *The Exceptional Child.* Scribner's, 1917, pp. 766.
A discussion of all types of exceptional children—feeble-minded, neurotic, brilliant, etc. Methods of child study are also indicated.

GROVES, E. R., *Personality and Social Adjustment.* Longmans, Green & Co., 1923, pp. 296.
This reference gives material on the factors going to make up personality, types of personality, and types of adjustments to environment.

GUTHRIE, L. G., *Functional Nervous Disorders in Childhood.* Hodder & Stoughton, 1909, pp. 300.
A rather old, but very good, treatment of such nervous conditions as neurasthenia, convulsions, chorea, etc., in children. Goes into the causes and manifestations of childhood difficulties.

HAINES, T. H., *Maryland Mental Hygiene Survey.* 20th Century Printing Co., 1921, pp. 96.
A brief report of the findings of an investigation into the number of defectives and insane in the State of Maryland.

HEALY, WM., *Pathological Lying, Accusation and Swindling.* Little, Brown & Co., 1915, pp. 278.
The children whose cases are here discussed are normal children who have gotten into difficulties which manifest themselves in the abnormal ways indicated by the title.

——— *Mental Conflict and Misconduct.* Little, Brown & Co., 1917, pp. 330.
An excellent presentation of case studies of normal children whose mental conflicts resulted in anti-social behavior. These studies show both the study and the adjustment of the individual. One of the best references for examples of case studies.

——— *Individual Delinquent.* Little, Brown & Co., 1922, pp. 830.
The first part of this reference deals with methods of studying delinquents. The second part presents many case studies of children brought before the juvenile court. Following the case studies is some discussion of causes and treatment of delinquency.

HENDERSCHOTT, F. C., and WEAKLEY, F. C., *The Employment Department and Employee Relations.* LaSalle Extension University, 1918, pp. 60.
A brief monograph, parts of which are concerned with the study and selection of employees.

HOAG, E. B., and WILLIAMS, E. H., *Crime, Abnormal Minds and the Law.* Bobbs, Merrill Co., 1923, pp. 405.
A good discussion of the relations between mental conditions, crime, and criminal procedure. Some space is devoted to methods of studying the criminal individual.

HUEY, E. B., *Backward and Feeble-minded Children.* Warwick & York, 1912, pp. 221.
A rather old reference on the subject, but it contains some good pictures and descriptions of feeble-minded children.

JELIFFE, S. E., *Technique of Psychoanalysis.* Nervous and Mental Disease Publishing Co., 1918, pp. 163.
This reference gives an excellent description of the way in which psychoanalysis is actually carried out by the physician.

JENNINGS, H. S., WATSON, J. B., MEYER, A., and THOMAS, W. I., *Suggestions of Modern Science Concerning Education.* Macmillan, 1921, pp. 211.
Meyer's lecture, "Mental and Moral Health in a Constructive School Program," is a brief general statement of the psychiatric reaction to certain school problems. The other essays also contain much, however, of value in this general connection.

JUDGE BAKER FOUNDATION, *Case Studies* (1-13), Boston, 1923.
Excellent, detailed studies of problem children.

KEMPF, E. J., *Psychopathology*. C. V. Mosby Co., 1920, pp. 702.
This book represents a largely new point of view and method of approach to the study of the various functional psychoses and their understanding as reactions to some type of sex conflict—the nature of the conflict and the type of response made determining the character of the psychosis. The author is probably extreme in some of his statements, but the book represents a really constructive effort to solve the problems of these patients.

KRAEPLIN, E., *Lectures on Clinical Psychiatry*. Baillière, Tindall, and Cox, 1913, pp. 368. (Trans. by Johnstone.)
An old, but excellent presentation of abnormal individuals; a different type is taken up in each chapter. The individual is described, something of his or her history told, symptoms pointed out, and the reasons for the diagnosis indicated.

LAIRD, D. A., *The Psychology of Selecting Men*. McGraw-Hill Book Co., 1925, pp. 369.
This reference discusses individual differences in the selection of men for different types of employment and the measurement of industrial progress. A very recent and good reference in the field covered.

——— *Increasing Personal Efficiency*. Harper & Brothers, 1925, pp. 204.
A clever little book (perhaps the best of its type) including chapters on memory, effective thinking, personality, fatigue, sleep.

LATTIMORE, E. I., *Some Illustrative Cases*. George Banta Pub. Co., 1917, pp. 125.
A series of 50 case histories—some of children, some of adults. Diagnoses vary from "social misfits" to "traumatic dementia."

LEWIS, B. G., *The Offender*. Harper & Brothers, 1917, pp. 371.
A good discussion of types of offenders, and of the causes and treatment of crime; some chapters are given to the topic of prevention.

LINK, H. C., *Employment Psychology*. Macmillan Co., 1920, pp. 440.
A very complete presentation of the fundamental principles in selecting men for positions, training them, reducing fatigue, increasing efficiency, etc.

MALCHOW, C. W., *The Sexual Life*. C. V. Mosley Co., 1921, pp. 306.
A discussion of the facts of sex as they concern the average individual. A sane, straightforward discussion.

MATEER, F., *The Unstable Child*, D. Appleton & Co., 1923, pp. 471.
A very good discussion of the causes of instability, and of the appropriate treatment of unstable children.

MAY, J. V., *Mental Disease: a Public Health Problem.* Richard Badger, 1922, pp. 544.
In addition to the usual descriptions of types of disease this reference contains a large section dealing with the extent, treatment, and prevention of diseased conditions.

Mental Hygiene Council of the Public Health Federation, *Mental Hygiene Survey of Cincinnati.* 1922, pp. 131.
A survey made chiefly through the schools, courts, social agencies, etc., to get an estimate of the number of abnormal individuals in a single large city.

MORGAN, J. J. B., *The Psychology of the Unadjusted School Child.* Macmillan, 1924, pp. 300.
An excellent discussion of the various ways in which children fail to become adjusted to their environment. Every teacher should read this reference.

MYERSON, A., *The Nervous Housewife.* Little, Brown & Co., 1920, pp. 261.
This author has given an excellent discussion of the effects of environment. He shows very clearly the maladjustments of the housewife. The reference is very readable and instructive.

PARMALEE, M. F., *Criminology.* Macmillan, 1923, pp. 522.
A standard book on this subject, with much material regarding the relations between mental abnormality and crime.

PARSONS, F., *Choosing a Vocation.* Houghton Mifflin, 1909, pp. 164.
Part I of this book deals with the investigation of individuals from the standpoint of the vocational counselor. The two remaining parts treat of job analysis and the task of getting individuals properly placed according to their interests and capacities.

PATON, S., *Signs of Sanity.* Scribner's, 1922, pp. 235.
This book is written in rather popular style but is sound in its general principles.

PAYNE, A. F., *Organization of Vocational Guidance.* McGraw-Hill Book Co., 1925, pp. 438.
This very recent reference contains some valuable material on the problems of personality in relation to vocational guidance and methods of case study in guidance work.

PFISTER, P. R., *Psychoanalysis in Education.* Henry Kimpton, 1922, pp. 176.
A good, sane discussion of the uses of psychoanalysis to determine the difficulties of children and so help in adjusting them to school life.

PINTNER, R., *Intelligence Testing.* Henry Holt Co., 1924, pp. 406.
Perhaps the best general summary of recent work in this whole field; describes various tests, and gives also results and applications.

RICHMOND, M. E., *What Is Social Case Work?* Russell Sage Foundation, 1922, pp. 268.
A very brief presentation of the main points of case-study method, not as good as the longer reference.

——— *Social Diagnosis.* Russell Sage Foundation, 1917, pp. 511.
This reference presents clearly and simply the methods to be used by the social worker. It gives, in fact, the best presentation of the way to make a case study (but does not give material on the "present condition"). Everyone is urged to consult this reference.

ROBIE, W. F., *Rational Sex Ethics.* Richard C. Badger, 1921, pp. 351.
A sane presentation of facts for the average reader. Either this book or the one by Malchow should be read.

ROSANOFF, A. J., *Manual of Psychiatry.* Wiley & Sons, 1920, pp. 684. (5th ed.)
A good manual from the medical point of view. Discusses mainly conditions that are obviously abnormal. Little emphasis on borderland conditions.

——— *Survey of Mental Diseases in Nassau County, New York.* State Hospital Press, 1917, pp. 125.
A survey of a single county to determine the number of insane individuals in the community.

ROSS, I. A., *The Common Neuroses.* Edward Arnold & Co., 1923, pp. 254.
A good, common-sense discussion of neurasthenia and hysteria; very largely non-technical.

SANDS, I. J., and BLANCHARD, P., *Abnormal Behavior.* Moffat, Yard & Co., 1923, pp. 482.
An excellent presentation of the cause and nature of various types of maladjustment—educational, social, industrial, etc. Various reasons for abnormal behavior such as glandular disturbances, personality types, mental disorders, use of drugs, environmental factors, etc., are discussed. One of the best references. Contains many case studies.

SAYLES, M. B., *The Problem Child in School.* Joint Committee on Methods of Preventing Delinquency, 1925, pp. 287.
Perhaps the best single reference on adjustment of the child to school and community. The book contains many highly illuminating case studies of different types of children.

Scott, W. D., and Clothier, R. C., *Personnel Management.* A. W. Shaw Co., 1923, pp. 643.
A very complete presentation, including many other matters than the study of the employee. Perhaps the best single reference in this field.

Sheffield, A. E., *Social Case History.* Russell Sage Foundation, 1920, pp. 219.
A presentation of history taking very similar to that of Richmond above. Gives examples of actual case histories. Discusses sources of information, selection of material to be put into the history, etc. A very good reference.

Sidis, B., *Causes and Treatment of Psychopathic Diseases.* Richard Badger, 1916, pp. 414.
Causes of mental disease are rather briefly discussed, the main emphasis being on fear as a causative factor. The treatment described is almost wholly concerned with hypnosis.

Solomon, H. C., and M. H., *Syphilis of the Innocent.* U. S. Interdepartmental Social Hygiene Board, 1922, pp. 239.
Probably the best single reference on the menace of syphilis to the general public. The cases presented acquired the disease in some wholly innocent fashion—not as a result of immoral conduct. A good reference for the non-medical reader on the ravages of the disease and of its social effects on the family and community.

Southard, E. E., *Shell Shock and Neuropsychiatry.* W. M. Leonard, 1919, pp. 975.
This book contains 589 case studies taken from records of shell-shocked soldiers. There is little organization or discussion of the material, but the book is an excellent source book for illustrative cases.

Southard, E. E., and Jarrett, M. E., *The Kingdom of Evil.* Macmillan, 1922, pp. 708.
Contains excellent case studies of all types found in psychiatric work. The last part is devoted to case study methods. An excellent reference—but not for the beginner.

Stekel, Wm., tr. Van Teslaar, J. S., *Psychoanalysis and Suggestion Therapy.* Moffat, Yard & Co., 1923, pp. 155.
A good, somewhat non-technical presentation of the technique, results, limits, and dangers of the method. More sane discussion than in many such books.

Terman, L. M., *The Intelligence of School Children.* Houghton Mifflin Co., 1919, pp. 317.
The first part is concerned with the nature and causes of individual differences in intelligence among children. Included

in the book are 51 case studies of brilliant children, together with some discussion of the problem of the supernormal child.

THOMAS, W. I., *The Unadjusted Girl.* Little, Brown & Co., 1923, pp. 261.
A discussion of the various factors in modern life that are influencing girls of to-day. Several good case studies. Good discussions of the sex impulses of the adolescent girl.

TREDGOLD, A. F., *Mental Deficiency.* Wm. Wood & Co., 1922, pp. 509 (4th ed.).
A very complete discussion of the causes, diagnosis, study, types and treatment of feeble-minded children.

VAN WATERS, MIRIAM, *Youth in Conflict.* New Republic Publishing Co., 1925, pp. 293.
This reference has two main sections. Under (1) the Problem of Delinquency, the author discusses the conflicts with home, school industry, social standards, etc., that result in delinquency. In the section on (2) Adjustment of Delinquency, the author presents the various means for adjusting youthful criminals so that further misdoing will be prevented. An excellent reference.

VARENDONCK, J., *The Psychology of Day Dreams.* Macmillan, 1921, pp. 362.
A very good discussion of the mechanisms underlying day dreaming, of the values and the dangers of day dreams.

WEAKLEY, F. E., *Applied Personnel Procedure.* McGraw-Hill Book Co., 1923, pp. 192.
A brief, but good presentation of the problems of personnel management. Relatively little of the material bears on the matter of interviewing or study of individuals.

WELLS, F. L., *Mental Adjustments.* D. Appleton & Co., 1917, pp. 324.
A general discussion of the mechanisms by which one adjusts to conflicts in the environment. Extreme forms used by the obviously insane are also discussed.

WHITE, W. A., *Mechanisms of Character Formation.* Macmillan, 1916, pp. 335.
This reference deals very ably with the various mechanisms such as symbolism, introversion, etc., by means of which individuals normally resolve conflicts.

——— *Principles of Mental Hygiene.* Macmillan, 1917, pp. 323.
One of the best references on this subject.

White, W. A., *Mental Hygiene of Childhood.* Little, Brown & Co., 1919, pp. 193.
A very good presentation of the needs and methods of a mental hygiene of childhood.

——— *Outlines of Psychiatry.* Nervous and Mental Disease Publishing Co. (7th ed.), pp. 320.
An excellent manual of a medical nature. Some space devoted to causes and treatment of insanity; but most of the book deals with abnormal mental conditions found among the insane.

White, W. A., and Jelliffe, S. E., *Modern Treatment of Nervous and Mental Disease.* Lea and Febiger, 1913, 2 Vols., pp. 862, 865.
An extensive and medical discussion of the causes and treatment of mental disease.

Wile, I. S., *The Challenge of Childhood.* Thomas Seltzer, 1925, pp. 305.
An excellent sympathetic discussion, chiefly by means of illustrative case studies, of problems appearing in children and methods of dealing with these problems. The problems range all the way from mal-nutrition to indulgent parent.

Williams, G., *The Problem of Restoration: A Clinical Study.* George Banta Publishing Co., 1918, pp. 117.
A series of 28 case histories written from the standpoint of the school. Children of all types are considered.

Woolley, H. T., and Ferris, E., *Diagnosis and Treatment of Young School Failures.* U. S. Bureau of Education, Bulletin, 1923, No. 1, pp. 115.
A finely careful and candid report regarding sixteen young children who were educational problems, and the efforts to deal with their difficulties in a special class.

Yealand, L. R., *Hysterical Disorders of Warfare.* Macmillan, 1918, pp. 252.
The nature of hysteria is very adequately brought out by the cases presented. Valuable suggestions as to treatment are given.

Yerkes, R. M., and La Rue, D. W., *An Outline for the Study of Self.* Cambridge University Press, 1914, pp. 25.
This brief monograph gives a case-study outline somewhat similar in character to that presented in the text. The reader would do well to look over this reference, as it is short and clear.

GLOSSARY

The brief glossary following lists the most commonly appearing technical terms in the total field covered by this volume. After each term is given a brief, somewhat colloquial definition. No attempt has been made at any exhaustive treatment of these concepts—in fact, the expert will doubtless often feel that the explanations are too simple to be adequate. But the glossary will, the writers believe, fulfill reasonably well the purpose for which it is intended—will facilitate first reading in this total subject for the beginner.

abnormal deviating from the usual or average. There is implied a deviation in the direction of morbidness or inadequacy.

adenoids a person suffering from adenoids has the passage from the nose to the throat blocked off more or less completely by an enlargement of the adenoid tissue in the nasopharynx. The result is mouth-breathing with consequent susceptibility to respiratory infections, deformation of the palate, and other unfortunate effects.

adolescence the period from about 12-21 (female) or 14-25 (male) during which the child changes into an adult. The period is one of marked physical, intellectual, and emotional development and change, and is often very difficult and distressing for both the individual and those with whom he is associated.

affect (noun) a feeling, or emotion; the term is commonly used in the psychoanalytic literature, and refers then, of course, primarily to sex feeling.

agoraphobia a morbid fear of open spaces.

alienist a physician who is a specialist in mental diseases.

amentia feeble-mindedness.

aments feeble-minded persons.

amnesia loss of memory.

anemia a deficiency in the amount of blood, or in the number of red corpuscles or of the hemoglobin.

anæsthesia loss or absence of sensation, either local or general. Such a condition may be due, in an abnormal individual, to some lesion in the nervous system, or to some functional disorder.

apathy marked lack of feeling, indifference to what is going on.

aphasia total or partial loss of the use or understanding of language; so in motor aphasia the person may, when shown a knife, call it a chair. In word deafness the individual may speak and write correctly; but his native tongue may be as unintelligible, when spoken to him, as a foreign language.

arteriosclerosis hardening of the arteries. In nervous and mental diseases the important condition is, of course, hardening of the cerebral arteries.

asymmetry lack of symmetry, as when a face is not alike on the two sides. Such facial or other asymmetry is fairly common among individuals constitutionally inadequate or peculiar mentally.

ataxic incoördinated, jerky; the word is perhaps most commonly employed in referring to the gait of the tabetic.

athetoid like the constant wiggling of fingers and toes seen in athetosis—a childhood nervous disease.

atrophy a wasting away of some part of the body, as of a muscle.

atypical unusual, different, unlike the average.

aura a peculiar sensation (often somewhat as of the touch of cold air) or condition (as a dreamy condition) sometimes preceding an epileptic or epileptoid attack, and giving warning of its approach. Hysterics sometimes have similar experiences.

autointoxication a condition arising from the presence of uneliminated toxic substances produced within the body.

automatism an action without any volition on the part of the individual or awareness of what he is doing.

blocking a sudden stop in the association of ideas, due apparently to approach to an emotional complex.

borderland (or borderline) those conditions which differ from the normal but not sufficiently to involve a change in personality and irresponsibility (that is, the individual is not psychotic) or general and permanent mental inadequacy (feeble-mindedness).

catalepsy a condition of muscular rigidity accompanied by more or less complete apparent stupor.

catatonia a form of dementia præcox characterized by either abnormal excitement (with apparent lack of emotion) or stupor, automatisms, mannerisms, sudden impulsive and apparently unmotivated acts, and sometimes negativism and peculiar postures. There is a more or less complete "withdrawal from reality."

cathartic method a method of dealing with the psychoneuroses in which a cure is effected by bringing the patient to talk about the emotional difficulty at the root of his trouble, thus freeing his mind of the suppressed emotional condition.

censor the emotional influences centering about moral sentiments, conventions, fear of disapproval of society, which bring it about that certain elementary urges (especially sexual desires) are repressed and show themselves only in indirect and disguised fashion.

chorea St. Vitus Dance. A nervous disease characterized by involuntary jerkings of the muscles, and in severe cases progressing to delirium. There is also usually a general irritability.

claustrophobia fear of closed spaces.

climacteric a period of important change in the total physiology as at puberty or (the more usual reference) the menopause.

clinic an organization of experts usually conducted with a medical school or other institution devoted to the examination and (usually free) treatment of patients.

clinical examination such thorough examination covering all the important elements in the case, as is made in a clinic.

clinical training training involving such opportunities for observation of patients as are offered by a clinic.

coma a state of profound stupor, or very complete insensibility and unconsciousness.

complex a repressed feeling or wish, and the ideas involved therewith, which may markedly influence behavior although the person may not be at all aware of the complex or have any appreciation that there is any connection between the repressed and apparently forgotten desire and his thoughts and actions.

compulsive act an act to which the individual seems driven, by some mysterious force, in spite of and contrary to his better judgment and will.

confidential exchange a central records office, for the social agencies and like organizations of a city, serving as a clearing house for information on cases.

conflict a struggle between one's elementary desires and one's sense of what is right or proper; a conflict frequently arises as a result of sex cravings to which the individual feels he cannot give expression because of the condemnation of society. These cravings are repressed, but may then disturb the individual's existence in various obscure ways, bringing about a psychoneurotic condition.

congenital existing at, or dating from, birth.

contracture a state of more or less permanent contraction or rigidity of a group of muscles.

convulsion a violent and involuntary contraction, or series of contractions, of the skeletal muscles, usually involving the whole body; seen especially in epilepsy and in diseases involving focal lesions in the brain.

cretinism a condition of physical defect, dwarfism and mental defect, associated with congenital disease of the thyroid gland.

cyanosis blueness of the skin—due primarily to some inadequacy in the circulation of the blood.

cyclothymic involving more or less periodic emotional extremes or disorders, as in manic-depressive insanity.

defense reaction a reaction, or set of reactions, made more or less unconsciously in avoidance of some unpleasant or humiliating situation, or situation for which the individual feels inadequate.

delirium a confused mental condition characterized by illusions and hallucinations, by restlessness and general irritability; most often the result of a severe infection.

delusion a false belief, or mistaken conviction which the individual holds to in the face of the most manifest evidence of its absurdity, as when a day laborer believes he is worth a billion dollars, or when a person thinks others are persecuting him although there is no reason whatever for such a belief.

dement one who is demented.

dementia impairment or loss of mental capacities, as a result of disease.

dementia præcox a mental disease group including a great variety of conditions, all characterized however by (a) early onset (usually in the late teens or twenties), (b) apathy and self-absorption with more or less complete withdrawal from reality and, usually (c) final dementia. The major difficulty seems to be of an emotional nature and to be due to wrong emotional development.

depression a state of marked emotional dejection. The emotional tone may be so extreme that the individual attempts suicide at every opportunity, is certain that he has committed "the unpardonable sin," and so on.

deterioration a decay of emotional life and of the mental capacities, resulting in dementia.

diabetes a disease attended by a persistent, excessive discharge of urine. The disease is fundamentally (diabetes mellitus) a disease of metabolism, failure to assimilate the sugars. It is now treated by insulin.

diagnosis a decision as to the nature of a diseased condition.

differential diagnosis the establishing of a diagnosis by a systematic consideration and elimination of all other diagnoses which might be offered.

dipsomania a morbid and uncontrollable craving for drink.

disorientated confused as to where one is, who one is, or the time and date. Thus, the patient in a hospital may think that he is

the King of England (disoriented as to person), that he is in his palace (disoriented as to place) and be unable to give the week, month or year (disoriented as to time).

displacement the shifting of an emotion from the circumstances originally arousing it to some associated, but in itself not emotionally charged, idea or object. So, a girl may show almost no feeling at mention of her mother's death (under very painful circumstances) but may have a marked emotional upset every time she hears the ringing of chimes such as happened to be ringing when her mother died.

dissociation a breaking up of the personality so that the individual has no control over certain of his acts or moods. He may then (as in a hysterical episode) behave in ways very different from his usual behavior with afterward no recollection as to what went on.

ductless without an excretory duct. Used to describe glands which pour their secretions directly into the blood stream, as the thyroid, suprarenal, etc.

echolalia an automatic repeating of words or sounds addressed to an individual. The patient simply repeats questions addressed to him, and will repeat the most meaningless or absurd statements.

echopraxia the automatic repetition of movements made by another person. So, if the examiner holds his arm above his head the patient puts up *his* arm also.

edema a swelling due to accumulation of watery fluid in the lymph spaces of the tissues.

ego the self.

emotional preoccupation a comparative obliviousness to what is going on around one (absent-mindedness) due to distraction of one's thought by some emotional problem which is continually getting the attention away from work or whatever else one is supposed to be doing.

enuresis involuntary discharge of the urine; nocturnal enuresis—bed-wetting.

epilepsy a chronic, episodic nervous disease characterized by attacks in which there are more or less complete convulsions with loss of consciousness. There are various forms of the disease, from "grand mal" attacks involving severe convulsions and coma, followed by delirium, to mild episodes involving little more than temporary dizziness, or automatic actions, which seem voluntary, but of which afterwards the patient has no recollection. Attacks may also occur primarily at night.

epileptic a person who has epilepsy.

epileptic equivalent an outburst of temper, a fainting spell, or other reaction that may take the place of the usual convulsion.

erogenous zone any part of the body (as hips, breasts, etc.) that when touched or stimulated may give sexual feelings.

erotic pertaining to the sex or love life.

erythrophobia fear of blushing.

etiology study of the causes of a disease or other condition.

eugenics the science that deals with factors leading to improvement of the human race through improving the racial stock, especially by proper mating.

euphoria a feeling of well-being, of perfect assurance that one is in excellent health and happiness, of genial self-contentment. The pathological case appears in the greatest of good spirits—self-satisfied, jovial, confident—may show expansive delusions consonant with his mood, as that he can fight six men, is worth ten million dollars, and so on.

exacerbation an increase in the severity of the symptoms of a disease, or an outbreak of a condition which has long been of mild chronic nature.

exciting cause the final factor bringing out into clear view a diseased condition—and often appearing on superficial examination to be the major cause of the trouble.

exhibitionism indecent exposure of the person—an act the doing of which gives pleasure to certain types of abnormal individual.

exophthalmic goiter a form of goiter having as its striking symptom an abnormal protrusion of the eyeball. There are various physical symptoms, as overaction of the heart, anemia, muscular weakness and marked mental and emotional instability. The major causative factor is probably excessive thyroid activity.

extroversion reaction to emotional difficulty by excessive activity, in contrast to introversion.

extrovert a person who tends to extroversion.

fanatic one who is excessively enthusiastic on some topic—as on some religious matter.

febrile pertaining to a fever.

feebleminded mental deficiency due to arrested mental development (in contrast to dementia). (See the chapter on "The Feebleminded.")

fetish a particular love-object—such as hair, foot, shoe, handkerchief—which comes to have especial interest and tendency to arouse sexual feeling.

fetishism sexual interest in, and pleasure from, a fetish.

fixation an arrest and crystallization of some phase of emotional life at some childhood level. So in cases of "mother fixation" the man's interest in women remains dominated by his early feeling toward his mother.

fixed idea an emotionally charged idea which is chronically in the mind of the patient to an abnormal degree; however, it so harmonizes with the patient's opinions and total personality that he does not recognize it as abnormal (so distinguished from an imperative idea, which the patient does so recognize).

flight of ideas a rapid succession of ideas which appear without any logical order, but are dependent upon whatever external stimulations may affect the individual. The individual simply runs on as this or that catches his attention.

focal infection an infection located in some particular gland or cavity, such as in the tonsils, the sinuses, the teeth. Many obscure physical and nervous conditions appear due to the toxins so generated.

focal lesion lesion in some particular area of the brain.

free association test a list of words, some referring to emotional topics, is read and the individual is asked to react to each with the first word which comes to his mind. Emotional complexes are shown by unusual delay in response, or some peculiar reply to words touching upon the complex.

frigidity sexual coldness or indifference.

function the natural and proper action of any thing; as the function of the liver or other organs.

functional (functional disease, functional psychosis) involving disorder in the activity of an organ or organs, but not due to any destruction or injury of tissue (at least so far as can be determined). Contrasted with organic (disease). So an hysteric may have a functional paralysis of the arm due to some emotional experience—a functional difficulty; a brain tumor case may show a superficially similar paralysis due to destruction of nervous tissue —an organic condition.

furor extremely violent outbursts, as of anger, often without the slightest apparent cause—seen in epileptics.

general paresis a disease of the brain, syphilitic in origin, involving progressive dementia, with disturbances of speech, delusions, increasing muscular weakness (see chapter on organic psychoses).

goiter an enlargement of the thyroid gland (see above, exophthalmic goiter and cretinism).

gonorrhea a venereal disease.

grand mal a typical epileptic attack involving convulsions.

hallucination a perception that has no external reality, as when a delirium tremens patient sees snakes or an alcoholic hallucinosis case hears voices abusing him, when there is nothing remotely resembling a snake about, and the room is quiet.

harelip a congenital deformity of the lip, involving a split.

hebephrenia a type of dementia præcox characterized by silliness, mannerisms, and general grotesqueness of ideas.

hemianæsthesia loss of sensation on one side of the body.

hemiplegia a paralysis affecting one half of the body.

homosexual a person attracted sexually by others of the same sex.

hydrotherapy treatment of disease by means of baths and mineral waters.

hyperæsthesia excessive sensitivity to stimuli,—usually to tactual stimuli.

hyperthyroidism a condition involving nervous irritability resulting from an oversecretion of the thyroid gland (or overdose of thyroid extract).

hypnosis a condition resembling somnambulism in which by various devices such as gazing steadily at some object, a soothing voice, and suggestion that such concentration will come about, the subject's attention is intensely concentrated upon one idea, and he is oblivious to all else. Being thus oblivious to circumstances it is possible to get him to do things which he would not do otherwise.

hypochondria (hypochondriasis)—a morbid concern about one's health with exaggerated attention to any possible symptom of disease (and often a hysteric imitation of various diseases). An unfounded belief that one is ill.

hypothyroidism thyroid insufficiency.

hysteria a nervous disease characterized by episodic attacks of an emotional nature involving various physical disturbances (such as apparent fainting spells or convulsions, anæsthesia, contractures, and paralyses, and often imitation of the symptoms of other diseases), and general emotional instability with a tendency toward explosions of emotions rather than suppressions. The condition usually appears in persons obviously emotionally excitable, and may be regarded as, fundamentally, a form of reaction to difficulties of emotional adjustment.

ideas of reference supposition by an individual (as a result of morbid sensitiveness) that the words and actions of others refer to himself—thus, any half heard conversation is sure to have his name in it, and include some unhappy reference to his affairs.

identification a method of vicarious emotional satisfaction, obtained (in day dreams, novel reading, the movies, etc.) by imagining

oneself as a hero, athlete, actress, or some other person who one supposes had the satisfactions one desires.

idiots the most extreme form of feeble-mindedness. The adult idiot has a mentality no better than that of a two-year-old child.

illusion a mistaken perception, as when one sees a coat hanging in a dark corner and mistakes it for a man.

imbecile a middle grade feeble-minded person—adult imbeciles have mental ages roughly between three and seven.

imperative idea see fixed idea.

inaccessibility a condition of either apathy or extreme concentration upon some inner conflict, such that the attention of the person cannot be obtained or answers elicited to questions.

incest sexual intimacy between persons so closely related that marriage is prohibited.

inferiority complex a feeling that one is not as good or as capable as others; a feeling of unworthiness, usually having its origin in some slight physical or social inferiority or difficulty of some sort that the person has been made acutely conscious of and cannot forget. The tendency of the individual is to shrink away from all situations where his difficulty might be evident, so that his life becomes narrowed or embittered. Or he may try to compensate for his difficulty by extreme conceit in some other field of action, and to cover up his inferiority by attempts at aggressiveness and self-assertion.

insane of unsound mind. Essentially a legal term, implying that the individual is so mentally diseased as not to be considered legally responsible.

insight understanding of oneself and of any mental or nervous difficulties one may have.

insomnia inability to sleep.

intercurrent disease a disease which occurs during the progress of some other disease.

introvert one who withdraws into himself and away from reality in times of emotional stress.

inversion homosexuality.

involution melancholia a condition involving morbid depression, anxiety, and restlessness, occurring after middle life.

I.Q. intelligence quotient; the per cent which a child's mental age is of his chronological age.

kleptomania an uncontrollable impulse to steal without any real desire or use for the stolen articles.

Korsakow's psychosis a disease usually due to alcoholic excesses and characterized especially by falsification of memory; the patient

remembers nothing of what happened the day before, but supplies a mass of fairly plausible but imaginary details regarding what occurred.

lesion a wound or injury; or area in which there is pathological change in the tissues.

libido love, sexual urge or desire—in a broad sense.

litigious contentious, especially to the extent that the individual frequently has recourse to lawsuits.

luetic syphilitic.

lumbar puncture the insertion of a hypodermic needle into the tissue about the lower spinal cord so as to obtain a specimen of the spinal fluid for examination.

macrocephalic having a large head.

malingering to sham or feign an illness.

mania a mental disorder involving markedly unstable attention, great activity, rapid flow of ideas and an excited and apparently happy, jocose mood.

manic-depressive insanity a type of mental disease in which attacks of mania and of depression more or less alternate with normal periods between.

mannerism a peculiar and recurring gesture, posture, or grimace; such peculiar actions appear frequently in certain types of mental disease—particularly dementia præcox.

masochism a form of sex perversion in which the individual obtains increased sex pleasure from being beaten or otherwise mistreated.

masturbation bringing about a sex reaction by manipulation of one's own sex organs.

melancholia a state of morbid and profound depression (see involution melancholia).

meningitis inflammation of the meninges (membranes) of the brain or spinal cord.

menopause the period of final cessation of menstruation, usually between 45 and 50.

mental deficiency feeble-mindedness.

mental hygiene the science devoted to the prevention of mental disease.

metabolism the sum-total of the normal chemical changes going on in living cells.

microcephalic having a pathologically small head, as some idiots.

migraine sick headaches, which come in periodical attacks.

monoplegia a paralysis of a single limb or part of the body.

morbid diseased, pathological.

moron belonging to the class of mental defectives nearest to the normal. Adult morons have mental ages, roughly, from 7 to 10.

mutism failure, or inability, to talk.

myopia nearsightedness.

myxedema a condition of deficiency of thyroid secretion (allied to cretinism) beginning in adult life and characterized by various physical changes, by slow movement and speech and general dullness.

narcotic a drug, such as opium, tending to relieve pain and produce sleep, but in larger doses producing coma or convulsions.

negativism an abnormal tendency to do just the opposite of what is asked. Thus, if a patient is asked to open his eyes he closes them as tightly as possible.

neo-salvarsan a drug used in the treatment of syphilis.

nervous breakdown, nervous exhaustion or *nervous prostration* terms used popularly to refer to neurotic episodes usually of a neurasthenic nature.

neuralgia an acute pain along the course of a nerve.

neurasthenia a nervous condition usually brought about by prolonged emotional strain and characterized by a general lowering of bodily tone, more or less depression, insomnia and headaches, and a fatigue all out of proportion to the effort put forth.

neurology the branch of medicine which is concerned with the study of the nervous system and its disorders.

neurosis any nervous disorder of a functional or "borderland" nature, such as neurasthenia, psychasthenia or hysteria (the term is used as largely synonymous with psychoneurosis).

neurosyphilis syphilis affecting especially the nervous system.

neurotic an individual of a type particularly susceptible to neuroses, or suffering from some neurosis.

nystagmus rapid involuntary oscillation of the eyeballs; due to ocular muscle spasm.

obsession an idea that is constantly in the mind, is accompanied by more or less anxiety, and which the patient cannot get rid of.

Œdipus complex (Freudianism) a complex in which incestuous desires are prominent; named after the Greek king who, unintentionally, killed his father and married his mother. An individual with such a complex has one of the parents as a love-object, having never overcome the infantile fixation.

onanism masturbation.

organic psychosis a mental disease due to some gross physical condition, such as syphilis, alcoholism, arteriosclerosis. To be contrasted with functional psychosis.

out-patient an individual who comes to a hospital dispensary or clinic for treatment, but is not a resident patient.

out-patient clinic the clinic where such patients (mentioned just above) come for treatment.

paranoia a mental disease characterized by systematized delusions of persecution or grandeur but with little or no apparent dementia.

paranoid pertaining to paranoia; involving delusions especially of persecution; of a very suspicious character, such as readily develops delusions of persecution.

paraphrenia a paranoid type of disease roughly described as midway between paranoid præcox and true paranoia.

paresis general paresis.

pathognomonic strikingly and decisively characteristic of a particular disease.

pathological morbid or diseased.

personnel manager an individual in a business concern who has charge of the hiring and placing of employees and general management of problems involving the adjustment of employees to and in their work.

perversion usually refers to sex perversions; a type of sexual response other than normal intercourse between the sexes.

petit mal a slight epileptic attack during which the individual does not fall, but usually loses consciousness for a moment and may perform some automatic act.

phantasy day dream.

phobia morbid fear.

predisposing causes the basic, underlying causes of mental disorders.

prodromata premonitory symptoms of a disease or condition—as change of disposition, headache, insomnia, physical malaise of a more or less ill-defined nature.

prognosis the foretelling of the probable course and outcome of a disease.

projection a method of avoiding emotional discomfort by projecting the trouble brought about by one's own inability or weakness to some other person or cause; thus, the poor golfer blames his clubs instead of his own lack of skill.

psychasthenia a nervous disorder characterized mainly by (1) phobias, obsessions, morbid doubts, impulsive acts, (2) feelings of insufficiency and unreality and (3) general nervous tension and anxiety.

psychiatrist a physician who specializes in mental diseases; an alienist.

psychiatry that branch of medicine that is concerned with the treatment of mental diseases.

psychoanalysis a method of treating nervous diseases which consists in analyzing the patient's past life to find the hidden complexes that are supposed to be at the root of the difficulties.

psychogenetic said of a neurotic or psychotic condition developing as a result of unfortunate emotional environment and circumstances—in contrast to mental ill health resulting from infections or other physical factors affecting the nervous system.

psychoneurosis see neurosis.

psychopathic a type of personality characterized especially by great emotional instability and unusual susceptibility to emotional stress. Or (in a more general sense) mentally abnormal.

psychopathy mental abnormality. (Sometimes used in a more narrow sense to refer to constitutional nervous and emotional instability.)

psychosis mental disease involving change in the personality, usually such that the individual is at times not wholly responsible.

psychotic having a psychosis.

puberty the age at which the reproductive organs become developed; about 12 years in girls and 14 in boys.

pupil adjustment the adjustment of the pupils in school as regards the nature and difficulty of the work done, also the relations with teachers, other children, etc., so that a child leads a happy, successful, emotionally healthy existence.

pupillary relating to the pupil of the eye.

pyromania a morbid fondness for setting fires.

rationalization the justification to one's self of what one wishes to do by various reasons which are excuses for action. Thus the student who goes to a "show" when he should be studying rationalizes his act by arguing that he needs relaxation.

reality the world of actual experiences as distinguished from the world of imagination and day dream. One important phenomenon in mental disease appears to be a withdrawal from reality (because of the individual's failure to make satisfying adjustments to things as they are) and living instead in a world of phantasy and day dream.

recidivist a chronic offender.

regression a going back to an earlier stage of emotional development as seen in those individuals who go back to childhood levels in their emotional life and interests, because of failure to adjust at a more mature emotional level.

remission a period in the progress of a mental disease during which the individual returns to an approximately normal condition, or at least markedly improves.

repression the attempted forgetting of such things as are painful and unpleasant. Ideas that are thus repressed are not, however, forgotten, but operate to affect the trend of the individual's thinking, his phantasies and his dreams.

resistance the unwillingness shown by a patient to the uncovering by the psychoanalyst of his painful and repressed ideas.

Romberg symptom (or sign) swaying of the body when the individual stands with the feet together and the eyes closed.

sadism the perversion of an individual who derives sexual pleasure from inflicting pain.

salvarsan a compound of arsenic used to treat syphilis.

schizophrenia dementia præcox; more specifically, the intrapsychic ataxia (lack of logical association between ideas), the splitting up of the personality, and the disorganization appearing in præcox cases.

sclerosis hardening of any tissue.

seclusive personality a type of personality usually described as "shut-in." The individual does not have the frequent and free-and-easy relationships with others as does the normal individual—and tends to develop an unhealthy day-dream life (tends to introvert). The person who later develops dementia præcox frequently shows a seclusive or shut-in personality.

segregation the separating of a certain type of individual from the general population; so, the feeble-minded may be put in an institution for defectives and thus kept from anti-social acts, and from reproducing their kind.

senescence old age.

senile psychosis a type of psychosis due primarily to the physical changes accompanying old age.

shut-in personality see "seclusive" personality.

siblings brothers and sisters.

somatic bodily, or pertaining to the body.

somnambulism "sleep-walking"; walking, writing or performing other complex acts while asleep, or in a sleep-like condition—and with no recollection afterwards of what was done.

stereotypy a morbid tendency to repeat the same acts or words (usually quite meaningless) over and over again, or to maintain the same attitude or posture.

sterilization rendering a person incapable of having offspring.

stigmata (of degeneracy) physical signs, such as an asymmetrical face or queer shaped head, which are most common in individuals mentally abnormal or defective.

strabismus crosseyedness.

stupor a condition of lethargy; unconsciousness.

subconscious an individual may not be aware of some strong emotional trend, or some emotional experience. Nevertheless that emotional trend or experience may influence the course of his thinking, his actions, his imaginings, and his dreams. The emotion or experience may be, under such circumstances, spoken of as in the "subconscious."

sublimation the diversion of the sexual energy to socially useful activities and interests.

suggestion the "implanting" of an idea in the mind of another so that the individual accepts it as true. So, in the treatment of neurotic conditions by suggestion the physician, in various ways, "suggests" to the patient that he is getting better.

symbolism the representation of an idea or feeling by some symbol or emblem. Thus, if a person dreams he is falling this may symbolize sexual indulgence (according to the Freudians).

symptom any item of information indicative of an individual's condition or health.

syndrome a group of symptoms usually appearing together, and together constituting the picture of the disease.

syphilis a venereal disease.

tabes dorsalis locomotor ataxia; a disease of the spinal cord, due to syphilis, and involving muscular incoördination, muscular atrophy, neuralgia, etc.

taboo forbidden by social usage; so, until recently all mention of venereal disease was taboo.

therapeutics the branch of medicine dealing with the treatment and curing of disease.

thyroid a ductless gland in the throat. It furnishes an internal secretion of influence upon the metabolism, absence of which results in cretinism (if the trouble is in childhood) or in myxedema (if in an adult) and an excess of which results in hyperthyroidism.

tic a slight muscular spasm or twitching, especially likely to involve the facial muscles. The individual is frequently unconscious of the spasm.

toxic poisonous.

transference the shifting of an emotion from one person, object, or idea to another.

trauma a severe wound or injury, such as a blow on the head. A psychic trauma is an experience of painful emotional character.

traumatic dementia dementia due primarily to head injury.

traumatic neurosis a neurotic condition following an injury of some kind. The individual appears physically injured, but his symptoms are primarily hysterical in nature.

tube feeding a method of feeding insane patients who refuse food. A rubber tube is forced down the throat (or through the nose into the throat) and liquid nourishment poured directly into the stomach.

tumor an abnormal growth in the body.

venereal any disease which is usually acquired through sexual intercourse.

verbigeration stereotypy of language; constant repetition of meaningless words or phrases.

vertigo dizziness.

Wassermann test a test for syphilis made upon a sample of the blood or of the spinal fluid.

waxy flexibility a state of extreme suggestibility in which the patient retains whatever attitudes his limbs are placed in by the examiner.

wish-fulfilling dream a dream that carries out some suppressed desire; such as the dream that some person is dead, which is interpreted to mean a desire for that person's death.

INDEX

The following index covers, in some detail, the main text; it does not, however, attempt reference to any but outstanding points in the case studies, since this illustrative material is obviously of secondary importance for reference work. In looking up any point the reader should also keep in mind the glossary. It has been planned that index and glossary should to a certain extent supplement each other. Therefore certain terms difficult to cover in any satisfactory way within the limits of a glossary definition have been omitted from the glossary, but taken care of in the index by full reference to explanations in the text. On the other hand, the glossary covers not only technical terms used in this volume * but also terms not used by the writers but common in other books in this general field.

The glossary is thus worth glancing over for its own sake—in addition to any aid it may give in reading the text. And it will aid in the reading of other material in the total field of abnormal psychology and psychiatry. Index and Glossary combined should be of distinct service in facilitating first reading in this difficult but fascinating subject.

Accidents, 19, 28, 89; *and see* Head injuries
Adenoids, 93
Adjustment, 111, 118-119, 132, 247, 276, 284, 289-291, 297-308
Admission of patients (to psychopathic hospital), 167, 282
Adolescence, 15, 19, 21-24, 139, 151, 166, 251-253, 300
After-care, 287-288
Age, of walking and talking, 20, 89, 220; and progress in school, 24, 224; onset of general paresis, 184; onset of mental disease, 251, 253, 274; age, mental, *see* Mental age
Alcohol and alcoholism, 5, 19, 28, 39, 182, 187-193, 244, 257, 269-270, 278, 287-288, 295-296
Alcoholic epilepsy, 189
Alcoholic hallucinosis, 188, 191-192
Alcoholic paranoid conditions, 189
Alcoholic pseudo-paresis, 189
Alcoholism, chronic, 187, 190-191
Amentia, distinguished from dementia, 216; *and see* Feeblemindedness
Amnesia, 46-47, 183, 187, 189, 196, 198, 199, 202
Anaemia, 111
Anaesthesia, 49, 116

* The method of selecting the terms for the glossary is worth mentioning in this connection. The writers had students with little or no knowledge of abnormal psychology read over the manuscript of this book, and also go over various other books dealing with this total subject, listing in each instance all those words with which they were not familiar. From a combined list so obtained the terms to be covered in the glossary were selected—in general those terms being kept which were found in several books and noted as hard by several students. The method seems of some possible interest, as a general procedure in glossary making.

Anxiety, 167, *and see* Worry
Apathy, 52, 147-148, 193, 252
Aphasia, 199
Apoplectic seizure, 196
Appearance and behavior, 41-42, 60, 94, 110, 131, 140, 147, 149, 154, 165, 177, 183-184, 193, 196, 201, 208, 212, 222; *and see* Illustrative case studies
Army results (regarding distribution of physical and mental traits), 85, 89, 92, 228, 261
Arrest of development, *see* Feeblemindedness
Arteriosclerosis, 19, 39, 198, 257
Association, 47, 110, 148-149, 165, 177, 208, 212, 223
Asthma, 111
Asymmetry, 40, 222
Attention, 45, 110, 124
Automatism, 149-150, 154

Baths, continuous, 167, 188, 284-285
Bed-wetting, *see* Enuresis
Behavior, *see* Appearance and behavior
Binet Scale, 50, 217-219, 225-226, 245-246
Biological selection, 293
Blindness, 40
Blood pressure, 39
Borderland conditions, 83, 105-143, 217, 230, 247-252, 262-265, 269-272, 279-283, 287, 289-291, 297-308
Brain tumor, 199-201
Broken homes, 88

Care of mentally diseased and defective individuals, 226-230, 278-291; *and see* Hospitals for mentally diseased
Case studies, illustrative, *see* Illustrative case studies
Case study method, 12-77, 243-254
Case study outline, 14-16, 36-37, 70-72, Appendix A (315-316)
Catatonia, 153-155, 159-160, 252
Catatonic excitement, 154-155, 252, 286
Catatonic stupor, 154-155, 252
Catharsis, 280
Causes of mental ill-health and deficiency, 267-277
Censor, 280
Childbirth, 6, 152, 163, 208-210, 275
Childhood, 4, 18-27, 53-56, 89-92, 108-109, 111, 130-131, 139, 150-151, 166, 174, 203, 220-221, 249-251, 270-272, 297-300
Chorea, 20, 96, 111, 249
Chronic alcoholism, *see* Alcoholism, chronic
Classification of mental disease and disability, 81-84, 85-95, 105-107, 144-147, 181, 214, 215-219
Climacteric, 20, 168
Clinic, out-patient, 282-283, 288
Clouding of consciousness, 183, 184, 188
Clumsiness, 222
Cocaine, 193, 195; *and see* Drugs
Cold pack, 286
Colleges, 4-5, 24, 133, 158-159
Complexes, 23, 55, 117, 270, 279-282, 298; *and see* Emotional conflict
Confidential exchange, 65
Conflicts, *see* Emotional conflicts
Confusion, 20, 151, 198, 202, 208, 244
Congenital syphilis, 185, 221
Constipation, 20, 110, 167, 285
Constitutional psychopathic inferiority, 217-218, 230, 234-236, 262
Contracture, 116
Control of mental disease and deficiency, *see* Mental hygiene
Control of psychotic individuals, 286
Convulsions, 20, 116, 182, 196, 201, 203, 220
Cost, of care of the abnormal, 1, 258
Cretinism, 212, 227
Crime and criminals, 2, 23, 51-52, 88, 130, 176, 202, 243-248, 263-264, 271-273
Crisis, *see* History of present crisis
Cyanosis, 39
Cyclothymic constitution, 252, *and see* Manic-depressive psychosis

Daydreaming, 93, 150-151
Deafness, 40-41
Deficiency, mental, *see* Feeblemindedness
Delayed walking, talking, *see* Age of walking and talking
Delirium in infection and exhaustion psychosis, 208-211
Delirium tremens, 187-188, 189
Delinquency, 2, 18-19, 23, 88, 130-133, 220-221, 243-248, 300
Delusions, 44, 144, 148, 153, 155-156, 164, 173-178, 188-189, 183, 184, 196, 244
Delusions of persecution, 155, 175, 188
Dementia, 148-149, 156, 193, 196, 198, 203, 264
Dementia praecox, 47, 52, 147-164, 173, 176, 251-253, 256-257, 268, 270-271, 275, 297
Dementia simplex, 153, 162-164
Depression, 20, 110, 151, 153, 155, 164-167, 184, 208, 251-252, 285
Deterioration, 153, 154, 156, 157, 173, 183, 184, 196, 203
Development, mental, 21-25, 28-29, 220-221, 268-269, 270-272, 294-301
Diabetes, 38, 208
Diagnosis, 71-72, 223-225, 243-254
Diet, 203, 285
Differential diagnosis, 71-72, 243-254
Discharge, from state hospital, 287-288, 292
Disorientation, 211
Dizziness, 20, 40, 110, 116, 182, 187, 195, 198, 201
Drugs, 19, 187-196, 245, 257, 269, 278, 285; *and see* Alcohol
Ductless glands, 39, 132, 211-214, 227, 272, 279
Duration of psychosis, 156, 166, 183-184, 195, 196

Ears, Deformities of, 40, 222
Economic history of the individual, 25-27, 92; of the family, 30, 89, 139; *and see* the following two heads
Economic incompetency, 2, 25-27, 106, 108, 131, 166, 182, 184, 204, 221, 225, 227, 229, 233, 236, 248-249, 264, 271
Economic problems and mental health, 2-3, 17-18, 22, 25-27, 30, 88-89, 100-101, 106, 131, 139, 182, 184, 221, 225, 248-249, 258, 264-265, 271, 276, 289-291, 300, 304-306
Education and problems of mental health, 3-4, 7, 16, 46, 89, 92, 98-103, 106, 108, 131, 220, 223-225, 228-230, 249-250, 276-277, 289-290, 294-301, 305-307
Educational history, study of the, 16, 24-25, 30
Emotional conditions, methods of investigating, 51-56
Emotional maladjustment and conflict, 21-23, 54, 93-94, 106, 109, 117-119, 129, 152, 157, 247, 248, 251, 270-272, 275, 276, 279-282, 284, 289-291, 298-299, 300, 303, 307
"Emotional thinking," 61-62, 93-94
Emotional trends, study of, 53-54
Emotionally unstable, the (the psychopathic personalities), 20, 28-29, 129-137, 246-247, 262, 264, 268, 293
Employment, management, 3, 12, 22, 25-27, 106, 182, 248, 265, 289-291; *and see* Economic problems and mental health
Enuresis, 20, 220
Environment and mental health, 7, 21-27, 29-30, 53-54, 107-109, 139, 151-152, 248, 250, 276, 289-291, 294-308
Epilepsy, 4, 16, 20, 28, 87-88, 201-207, 244, 255, 257, 259-260, 269
Epilepsy, and feeble-mindedness, 202-203
Epileptic equivalent, 201
Epileptic temperament, 202
Etiology, *see* Causes
Eugenics, 6, 292-294; *and see* Heredity
Examination of an individual, 35-58; *and see also* 243-254

Exciting cause, 267, 274-275; treatment of, 283-284
Excitement, 20, 52, 148, 154, 164-165, 184-185, 244, 245, 284-285, 286
Exhaustion, as cause of mental disease, 275; prevention of exhaustion in mental disease, 284
Exhaustion psychosis, 208, 210-211
Exophthalmic goiter, 212-213
Extent of mental disease, 1-5, 255-266
Eyes, abnormalities of, 39-41, 92, 182, 249

Fainting spells, 20, 116, 201-202
Falsification of memory, 46, 177, 189
Family dissension, 90
Family history, *see* History of the family
Far-sightedness, 249
Fatigue, 106, 110-111, 167
Fears, morbid, 124-125
Feeble-minded, the, 2-4, 28, 51, 84, 87, 96, 100-101, 202, 215-236, 243-253; number of feeble-minded, 253-254, 260-265; causes, 268, 271, 276; control of feeble-mindedness, 228, 290, 294-295
Fever, 208-209
Flight of ideas, 48, 165, 195
Focal infections, 6, 38, 272, 279
Focal signs, 199
Follow-up work, Appendix A (315-316); *and see also* 287-288
Food, refusal of, 149, 154, 157, 285
Forgetfulness, 183, 187, 189; *and see* Memory and Amnesia
Functional Psychosis, 82-83, 144-179; differentiation of, in adolescence, 251-252

General emotional tone, study of, 52-53
General intellectual level, 49-51, 92, 110, 116, 151, 174, 187; *and see* Feeble-mindedness
General paresis, 5, 181-187, 253, 257, 273, 278; *and see* Syphilis
Genius, 86
Glands, *see* Ductless glands
Goiter, *see* Ductless glands and Exophthalmic goiter
Grand mal, 201, 204-206; *and see* Epilepsy
Grandeur, delusions of, 183; *and see* Delusions
Gross brain disease, 198-201
Group tests of intelligence, *see* Mental tests

Hallucinations, 48, 144, 153, 155-156, 175, 188, 208, 244
Hallucinosis, alcoholic, *see* Alcoholic hallucinosis
Handwriting, 182
Headaches, 21, 110, 153, 175, 182, 201
Head injury, 89, 199, 272; *and see* Accidents
Hebephrenia, 153-154, 158-159; *and see* Dementia praecox
Heredity, 6, 27-28, 87, 107-108, 220, 267-269, 270-271, 292-293; *and see* Family history
History and present condition, 35
History of family, 27-30, 108, 115, 130-131, 139, 150, 165-166, 173, 181, 187, 193, 196, 198, 202, 209, 220, 226, 271
History of individual, 19-27, 108, 115-116, 131-132, 139, 150-152, 165-167, 173-176, 181, 187, 193, 196, 198, 209, 220-221, 270-271
History of the present crisis, 16-19, 108-109, 116, 139, 152-153, 166, 182, 188, 222
History taking, 13-34, 59-74
Hobo, 42, 153, 264
Homosexuality, 133
Hospitals for the mentally diseased, 20, 132, 145, 152, 157, 167, 177-178, 189, 244, 255-258, 284-287
Hypnotism, 280
Hypochondria, 20, 110, 184, 203, 302
Hysteria, 4, 49, 107, 115-123, 247

Ideas of reference, 175
Idiot, 218, 230-231

Illegitimacy, 209, 275
Illiterates, 273-274
Illustrative case studies
Normal individuals, 32-33, 56-57, 71-72, 95-104
Neurasthenia, 97-104
Hysteria, 119-123
Psychasthenia, 125-129
Emotionally unstable, 133-137
Mentally peculiar, 140-142
Dementia praecox, 158-164
Manic-depressive, 168-171, (*also* 33-34, 58-59, 72)
Involution melancholia, 171-172
Paranoia, 178-179
General paresis, 185-187
Alcoholic psychosis, 190-192
Psychoses due to morphine, 194-195
Senile psychoses, 197-198
Gross brain disease, 198-201
Epilepsy, 204-207
Psychosis due to thyroid gland, 212-213
Psychosis due to exhaustion, 210-211
Psychosis due to infection, 209-210
Feeble-minded, 230-236
Imbeciles, 218, 232-233
Immigration, 273
Immorality, *see* Delinquency
Inaccessibility, 148
Indiana report regarding number of mental defectives, 258-260
Indifference, *see* Apathy
Industry and mental health, 265-289, 305-306; *and see* Economic problems and mental health
Infection psychosis, 208, 209, 210
Inferiority complex, 23, 151, 298
Insomnia, 20, 21, 110, 152, 167, 182, 285
Instability, *see* Emotional instability
Institutions for epileptics, 2, 259-260
Institutions for the feeble-minded, 1, 31, 132, 227-229, 255, 260, 294
Intelligence, *see* General intellectual level and feeble-mindedness
Interviewing, 60-63
Intoxication psychoses, 187-196; *and see* Alcohol
Involution melancholia, 167, 171-172, 274
I. Q., 50, 225, 246

Jealousy, ideas of, 189
Jewish race and mental health, 111-112, 114-115, 273
Judgment, 43-45; *and see* Delusions
Juvenile paresis, *see* Congenital syphilis

Kleptomania, 124, 247
Knee-jerk, 39, 85, 182
Korsakow's (or Korsakoff's) psychosis, 189

Lead poisoning, 195
Legal responsibility, 145, 247
Love-affairs, 23, 152, 267
Lumbar puncture, 38, 183, 253

M.A., *see* Mental age
Maladjustment, *see* Emotional maladjustment
Malingering, 245, 246-247
Mania, *see* Manic-depressive insanity
Manic-depressive insanity, 4, 33-34, 44-47, 52, 57-58, 72, 164-172, 244, 251-252, 253, 268, 284-285
Mannerisms, 41, 152, 155, 252
Marriage, 201, 273-274, 276; *and see* Eugenics
Masturbation, 20, 54, 55, 90-91, 281
Mayo, Dr. W. J., 2, 105
Measurement, Mental, *see* Mental tests
Medical history, 19-20, 28; *and see* History of the family *and* History of the individual
Melancholia, 167-168, 171-172
Memory, 45-47, 110, 148, 177, 202, 223

Mental age, 218-219; *and see* Mental tests
Mental deficiency, *see* Feeble-mindedness
Mental examination, *see* Examination of the individual
Mental hygiene, 7, 292-308
Mentally peculiar, 137-142, 262
Mental tests, 49, 51, 226, 246, 250; *also see* General intellectual level
Mercury poisoning, 195
Morons, 218-219, 233-234; *and see* Feeble-mindedness
Morphine, 193-195

National committee for mental hygiene, 255
Negativism, 149-150
Negro race and mental disease, 273
Neologism, 149
"Nervous breakdown," 2, 20; *and see* Neuroses, especially Neurasthenia
Neurasthenia, 2, 107, 109-115, 199, 251
Neurological signs, 39, 85, 182, 199
Neuroses, *see* Hysteria, Neurasthenia and Psychasthenia; *also* Emotional maladjustments
Neurosyphilis, *see* Syphilis

Objectivity in records, 68-69
Obsession, 45, 124
Occupation, 26-27, 30; *and see* Economic problems and Mental health
Occupational therapy, 157
Old age, 275; *and see* Senile psychoses
Operations, 279
Organic and functional disorders, the distinction between, 83, 146
Organic psychoses, 146, 181-214, 257
Orientation, *see* Disorientation
Out-patient clinic, 282-283, 288

Paralysis, 39, 116, 184, 199-201; *and see* General paresis
Paranoia, 173-179
Paranoid praecox, 153, 155-156, 161-162
Perception, 48; *and see* Hallucinations and anaesthesia
Persecution, delusions and ideas of, *see* Delusions of persecution
Personality, psychopathic, *see* Emotionally unstable
Petit mal, 201, 206-207
Phobias, 125
Physical defects among school-children, 40-41, 92-93, 249
Physical examination, 37-41, 244-245, 249, 302
Play, 23, 150, 174, 220, 224, 250, 276; *and see* Recreation
Poor farm, 260
Population of institutions, 255-257
Predisposing cause, 267-274
Pre-school child, 297-298
Present condition, study of, 35-58
Prevalence of mental disorders, *see* Extent
Prevention, *see* Mental hygiene
Problem child, 249-250
Prognosis, 140, 156, 167, 183, 184, 188, 198
Prohibition, 257, 296; *and see* Alcohol
Prolonged baths, *see* Baths, continuous
Prostitute, 219, 220-221, 264, 296
Psychasthenia, 107, 123-129
"Psychic ataxia," 150
Psychoanalysis, 280-281
Psychological tests, *see* Mental tests
Psychoneuroses, *see* Neuroses
Psychopathic personality, *see* Emotionally unstable
Psychopathy, 243-248; *and see* Glossary
Psychosis, nature of, 144-146
Puberty, *see* Adolescence
Pupil, *see* Neurological signs

Race, in relation to mental health, 273
Rationalizing, 93
Records, 65-72

Recreation, 151, 276, 288, 290, 300, 304; *and see* Socialization and play
Reeducation, 111, 118, 281-282, 288; *and see* Adjustment
Reflexes, *see* Neurological signs
Reformatories, 228, 260
Remissions, 156, 184
Repression, *see* Emotional maladjustment and conflict
Research, facilitation of, 66
Responsibility, legal, *see* Legal responsibility
Responsibility of society, 263-264, 276-277; *and see* Environment and mental health
Rest, 151, 284; *and see* Fatigue and insomnia
Restraint in handling insane cases, 284
Retardation in school, *see* Educational history
Retention, *see* Memory
"Romancing," 189
Romberg, 39
Rural population, frequency of mental trouble in, 273

Salvarsan, 184, 278
Schools and mental health, *see* Education
Schools for the feeble-minded, *see* Institutions for the feeble-minded
Seclusiveness, *see* Shut-in personality
Segregation of defectives, 227, 293-294
Senile psychoses, 196-198, 257
Sensory defects, 40, 92-93, 249
Sex, problems of, 20, 23, 29, 54, 73, 90-91, 109, 130-131, 151, 157, 182, 189, 214, 219, 221, 239, 267, 270, 279, 280, 281, 297, 298
Sexual psychopath, 132-133
"Shut-in" personality, 150-151, 251, 269; *and see* Socialization
Silliness, 52, 148, 154, 223
Simulation, 245, 246, *see* Malingering
Sleep, *see* Insomnia
Social feeble-mindedness, 224, 246-247
Social heredity, 271
Social history, 21-23, 29; *and see* Socialization
Socialization, 21-24, 108, 119, 132, 139, 150-153, 174, 224, 251, 270, 277, 281, 299, 300, 304; *and see* Recreation
Social worker, 15, 30, 37, 41, 59, 60, 64, 65, 118, 131, 145, 157, 181, 192, 248, 288, 291
Southard, E. E., 3
Special classes, 250
Speech defects and disorders, 39, 182, 187
Spinal fluid, 67, 183
Stanford revision, *see* Binet scale
Stereotypy, 155
Sterilization of defectives, 293
Stigmata of degeneracy, 40, 222
Stupor, 154-155, 165, 201
Success and mental health, 298; *and see* Inferiority complex
Suicides, 17, 20, 164, 165, 168, 285
Summary of case study, 70-72
Supernormality, 86
Supervision of feeble-minded in community, 118, 228-229, 288-291, 294-295
Surveys, regarding number of defectives, 255-258, 259-261
Symptoms, social, 71
Syphilis, 5, 38, 88, 181-187, 269, 295-296; *and see* Congenital syphilis

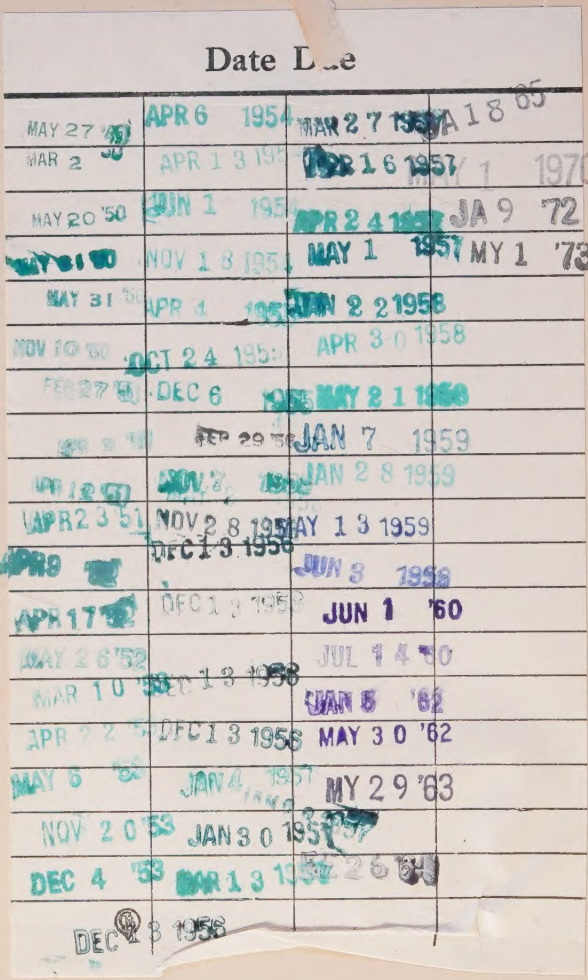
Taboo, 277
Tests, *see* Mental tests
Thyroid, 39, 132, 212; *and see* Ductless glands
Toxic psychoses, 187-196; *and see* Alcohol
Training of feeble-minded, 6, 226-229
Tramps, *see* Hobo
Traumatic dementia, 199
Treatment
Neurasthenia, 111, Hysteria, 118-199, Dementia praecox, 156-157, Manic-depressive, 167, Paranoia, 177-178, General paresis, 184, Alcoholics,

187, Epilepsy, 203, Feebleminded, 226-229, General, 278-291
Tremors, 187
Truancy, 23, 250
Tube feeding, 149, 285
Tuberculosis, 19, 28, 38, 208
Tumor, *see* Brain tumor

Unconsciousness, *see* Stupor, Fainting, Convulsions
Unemployment, 3, 26-27, 248, 262, 264, 290, 304; *and see* Economic incompetency

Venereal disease, *see* Syphilis
Visual defects, 39, 92, 182, 249
Voluntary admission, 167, 283

Wassermann, 38, 182
Waxy flexibility, 154
Weight, 40, 167, 183, 193
Withdrawal from reality, 147, 150-151; *and see* Dementia praecox
"Word salad," 149
Work, *see* Unemployment, Occupational therapy, Treatment
Worry, 53, 109, 151, 167


Date Due
APR 6 1954
APR 13 195
JUN 1 195
NOV 18 1954
APR 4 195
OCT 24 195
DEC 6
FEB 29 56
NOV 28 195
DEC 13 1956
DEC 13 1956
DEC 13 1956
JAN 4 1957
JAN 30 195
MAR 13
DEC 18 1956
MAR 27 1957
APR 16 1957
APR 24
MAY 1 1957
JUN 22 1958
APR 30 1958
JAN 7 1959
JAN 28 1959
MAY 13 1959
JUN 3 1959
JUN 1 '60
JUL 14
JAN 5 '62
MAY 30 '62
MY 29 '63
JA 18 65
MAY 1 1970
JA 9 '72
MY 1 '73

RC601
.P93

84457

ST. OLAF COLLEGE
RC6[illegible] P93
Press[illegible]cienc
3 0111 00314 6809